Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

Regional Health Partnership Nine

RHP Lead Contact: *Jody Springer*
SVP, Strategy and Business Development
Parkland Health & Hospital System
5201 Harry Hines Blvd.
Dallas, Texas 75235
jody.springer@phhs.org
(214) 590-4605

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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

Section I. RHP Organization

Please find below the list the participants in RHP 9 by type of participant.

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, Public Hospital	127295703	1756004221 4 002	Non-state public	Dallas County Hospital District (d/b/a Parkland Health & Hospital System)	Ted Shaw Interim Chief Financial Officer	5201 Harry Hines Blvd. Dallas, TX 75235 ted.shaw@phhs.org 214.590.8097
IGT Entities *(specify type of government entity, e.g. county, hospital district)*						
Hospital District, Public Hospital	127295703	1756004221 4 002	Non-state public	Dallas County Hospital District (d/b/a Parkland Health & Hospital System)	Ted Shaw Interim Chief Financial Officer	5201 Harry Hines Blvd. Dallas, TX 75235 ted.shaw@phhs.org 214.590.8097
State University	126686802	1756002868 4 003	State owned, public	The University of Texas Southwestern Medical Center	Bruce Meyer, MD EVP Health Systems Affairs	5323 Harry Hines Blvd. Dallas, TX 75390 Bruce.Meyer@UTSouthwestern.edu 214.648.9794
State University Hospital	175287501	1753175630 6 003	State owned, public	UT Southwestern Medical Center - University Hospital	Bruce Meyer, MD EVP Health Systems Affairs	5323 Harry Hines Blvd. Dallas, TX 75390 Bruce.Meyer@UTSouthwestern.edu 214.648.9794

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)
County, Local Health Department	121758005	1756000905 6 004	Non-state public	Dallas County Health and Human Services	Zachary Thompson, Executive Director	2377 North Stemmons Freeway Dallas, Texas 75207-2710 Zachary.thompson@dallascounty.org 214.819.2000
County, Local Health Department	136360803	1756000920 5 010	Non-state public	Denton County Health and Human Services	Bing Burton, Director	535 S. Loop 288, Suite 1003 Denton, TX 76205 Bing.burton@dentoncounty.com 940.349.2913
County MHMR	135234606	1751368151 4 009	Non-state owned public	Denton County MHMR Center	Pam Gutierrez, CEO	PO Box 2346 Denton, TX 76202 pamg@dentonmhmr.org 940.565.5260
Hospital District	135235306	1752302928 2 501	Non-state owned public	Ector County Hospital District	John O'Hearn, MHA Director of Regional Development	Medical Center Health System PO Box 7239 Odessa, TX 79760 johearn@echd.org Office 432-640-2429
County MHMR	137252607	1751285603 4 000	Non-state public	Dallas County MHMR d/b/a Metrocare	Linda Thompson, Interim CEO	1380 River Bend Dr. Dallas, TX 75248 Linda.Thompson@metrocareservices.org 214.743.1258
County MHMR	121988304	1752833823 3 000	Non-state public	Lakes Regional MHMR Center	John Delaney Executive Director	P.O. Box 747 400 Airport Rd. Terrell, TX 75160 johnd@lrmhmrc.org 972.524.4159 ext. 1150

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)
State Department Terrell State Hospital	137919003	3537537537 1 000	State public	Texas Department of State Health Services	Olga Rodriguez Director, Center for Program Coordination and Health Policy	Texas Department of State Health Services 1100 West 49th Street Austin, Texas 78756-3199 512.776.7181 Olga.Rodriguez@dshs.state.tx.us
State University	009784201	3709709709 3 001	State owned, public	Texas A&M Health Science Center, Baylor College of Dentistry	Daniel L. Jones DDS, PhD Professor & Chair Department of Public Health Sci.	3302 Gaston Avenue Dallas, Texas djones@bcd.tamhsc.edu (214) 828-8350
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)*						
Public Hospital	127295703	1756004221 4 002	Non-state public	Dallas County Hospital District (d/b/a Parkland Health & Hospital System)	Ted Shaw Interim Chief Financial Officer	5201 Harry Hines Blvd. Dallas, TX 75235 ted.shaw@phhs.org 214.590.8097
State University Hospital	175287501	1753175630 6 003	State owned, public	UT Southwestern Medical Center - University Hospital	Bruce Meyer, MD EVP Health Systems Affairs	5323 Harry Hines Blvd. Dallas, TX 75390 Bruce.Meyer@UTSouthwestern.edu 214.648.9794

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State University	126686802	1756002868 4 003	State owned, public	UT Southwestern Medical Center - University Hospital	Bruce Meyer, MD EVP Health Systems Affairs	5323 Harry Hines Blvd. Dallas, TX 75390 Bruce.Meyer@UTSouthwestern.edu 214.648.9794
Physician Practice Plan affiliated with a Health Science Center	126686802	1756002868 4 003	State owned, public	University of Texas Southwestern Medical Center – Faculty Plan	Bruce Meyer, MD EVP Health Systems Affairs	5323 Harry Hines Blvd. Dallas, TX 75390 Bruce.Meyer@UTSouthwestern.edu 214.648.9794
Private hospital	195018001	1208889358 6 002	Private	Baylor Medical Center at Carrollton (Trinity)	Fred Savelsbergh, Chief Financial Officer	3500 Gaston Avenue Dallas, TX 75246-2017 fredsa@baylorhealth.edu 214.820.3724
Private hospital	121790303	1751037591 2 009	Private	Baylor Medical Center at Garland	Fred Savelsbergh, Chief Financial Officer	3500 Gaston Avenue Dallas, TX 75246-2017 fredsa@baylorhealth.edu 214.820.3724
Private hospital	121776204	1752586857 0 000	Private	Baylor Medical Center at Irving	Fred Savelsbergh, Chief Financial Officer	3500 Gaston Avenue Dallas, TX 75246-2017 fredsa@baylorhealth.edu 214.820.3724
Private hospital	139485012	1751837454 5 000	Private	Baylor University Medical Center	Fred Savelsbergh, Chief Financial Officer	3500 Gaston Avenue Dallas, TX 75246-2017 fredsa@baylorhealth.edu 214.820.3724

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Private children's hospital	138910807	1750800628 9 001	Private	Children's Medical Center Dallas	Regina Montoya, Senior Vice President, External Relations and General Counsel	1935 Medical District Drive, F3.22 Dallas, Texas 75235 regina.montoya@childrens.com 214.456.0367
Private hospital	111905902	1621682213 6 002	Private	Denton Regional Medical Center (HCA)	Kathleen Sweeney, Vice President of Community Resources	HCA North Texas Division 6565 N. MacArthur Blvd. Suite 350, Irving TX 75039 Kathleen.sweeney@hcahealthcare.com 972.401.8757
Private hospital	094194002	1954537720 2 011	Private	Doctor's Hospital at White Rock Lake	Wes James, VP Regional Finance	Tenet Healthcare Corporation 1445 Ross Avenue, Suite 1400 Dallas, TX 75202 469.893.6652
Private hospital	020979301	1621650582 2 002	Private	Las Colinas Medical Center (HCA)	Kathleen Sweeney, Vice President of Community Resources	HCA North Texas Division 6565 N. MacArthur Blvd. Suite 350, Irving TX 75039 Kathleen.sweeney@hcahealthcare.com 972.401.8757
Private hospital	094192402	1621682210 2 002	Private	Medical Center of Lewisville (HCA)	Kathleen Sweeney, Vice President of Community Resources	HCA North Texas Division 6565 N. MacArthur Blvd. Suite 350, Irving TX 75039 Kathleen.sweeney@hcahealthcare.com 972.401.8757

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Private hospital	020943901	1621682198 9 003	Private	Medical City Dallas Hospital (HCA)	Kathleen Sweeney, Vice President of Community Resources	HCA North Texas Division 6565 N. MacArthur Blvd. Suite 350, Irving TX 75039 Kathleen.sweeney@hcahealthcare.com 972.401.8757
Private hospital	126679303	1750800661 0 324	Private	Methodist Charlton Medical Center	Michael Schaefer, Chief Financial Officer	1441 North Beckley Ave Dallas, TX 75203 michaelschaefer@mhd.com 214.947.4510
Private hospital	135032405	1750800661 0 032	Private	Methodist Dallas Medical Center	Michael Schaefer, Chief Financial Officer	1441 North Beckley Ave Dallas, TX 75203 michaelschaefer@mhd.com 214.947.4510
Private hospital	209345201	1264193362 2 001	Private	Methodist Richardson Medical Center	Michael Schaefer, Chief Financial Officer	1441 North Beckley Ave Dallas, TX 75203 michaelschaefer@mhd.com 214.947.4510
Physician/Dentist Practice affiliated with a Health Science Center	009784201	37097097093001	State owned, public	Texas A&M Health Science Center, Baylor College of Dentistry	Daniel Jones DDS Professor & Chair Department of Public Health Sciences	3302 Gaston Avenue Dallas, Texas djones@bcd.tamhsc.edu (214) 828-8350
Private hospital	020908201	1751047527 4 501	Private	Texas Health Presbyterian Hospital Dallas	Ron Long, Chief Financial Officer	612 E. Lamar Boulevard Arlington, TX 76011 ronlong@texashealth.org 682.236.7930

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Private hospital	217744601	1432008974 2 002	Private	Texas Health Presbyterian Hospital Denton	Ron Long, Chief Financial Officer	612 E. Lamar Boulevard Arlington, TX 76011 ronlong@texashealth.org 682.236.7930
Private hospital	094140302	1752771437 6 002	Private	Texas Health Presbyterian Hospital Kaufman	Ron Long, Chief Financial Officer	612 E. Lamar Boulevard Arlington, TX 76011 ronlong@texashealth.org 682.236.7930
County Local Health Department	121758005	1756000905 6 004	Non-state public	Dallas County Health and Human Services	Zachary Thompson, Executive Director	2377 North Stemmons Freeway Dallas, Texas 75207-2710 Zachary.thompson@dallascounty.org 214.819.2000
County MHMR	137252607	1751285603 4 000	Non-state public	Dallas County MHMR d/b/a Metrocare	Linda Thompson, Interim CEO	1380 River Bend Dr. Dallas, TX 75248 Linda.Thompson@metrocareservices.org 214.743.1258
County Local Health Department	136360803	1756000920 5 010	Non-state public	Denton County Health and Human Services	Bing Burton, Director	535 S. Loop 288, Suite 1003 Denton, TX 76205 Bing.burton@dentoncounty.com 940.349.2913
County MHMR	17513681514	1751368151 4 009	Non-state owned public	Denton County MHMR Center	Pam Gutierrez, CEO	PO Box 2346 Denton, TX 76202 pamg@dentonmhmr.org 940.565.5260

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County MHMR	121988304	1752833823 3 000	Non-state public	Lakes Regional MHMR Center	John Delaney Executive Director	P.O. Box 747 400 Airport Rd. Terrell, TX 75160 johnd@lrmhmrc.org 972.524.4159 ext. 1150
UC-only Hospitals *(list hospitals that will only be participating in UC)*						
Private hospital	151691601	1752834135 1 001	Private	Baylor Heart & Vascular Center	Fred Savelsbergh, Chief Financial Officer	3500 Gaston Avenue Dallas, TX 75246-2017 fredsa@baylorhealth.edu 214.820.3724
Private hospital	021003101	1751765385 7 002	Private	Baylor Specialty Hospital	Fred Savelsbergh, Chief Financial Officer	3500 Gaston Avenue Dallas, TX 75246-2017 fredsa@baylorhealth.edu 214.820.3724
Private hospital	021224301	1621797829 1 002	Private	Green Oaks Hospital Subsidiary d/b/a Green Oaks Hospital	Kathleen Sweeney, Vice President of Community Resources	HCA North Texas Division 6565 N. MacArthur Blvd. Suite 350, Irving TX 75039 Kathleen.sweeney@hcahealthcare.com 972.401.8757
State hospital	137919003	3537537537 1 000	State owned, public	Terrell State Hospital	Olga Rodriguez Director, Center for Program Coordination and Health Policy	Texas Department of State Health Serv. 1100 West 49th Street, Austin, Texas 78756-3199 512.776.7181 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)
Other Stakeholders *(specify type)*						
County Medical Associations/Societies				Dallas County Medical Society	Michael Darrouzet Executive Vice President/CEO	PO Box 4680 Dallas, TX 75208-0680 darrouzet@dallas-cms.org 214.948.3622
County Medical Associations/Societies				Denton County Medical Society	Brenda Holland, Executive Secretary — John G Flores, MD, Marilyn Janke, MD	3537 S. Interstate 35 E. Suite 302 Denton, TX 76210 dcmsoc@verizon.net (940) 566-3923
Regional Public Health Directors				N/A		
Other significant safety net providers within the region (specify type)				North Texas Behavioral Health Authority	Alex B. Smith, Executive Director	1201 Richardson, Ste 270 Richardson, TX, 75080 alsmith@ntbha.org 214-366-9407
				Adapt Community Solutions, Inc.	Preston Looper, MS, LPC-S Chief of Clinical	2600 N. Stemmons Freeway, Suite 182 Dallas, TX 75207 214-966-4607 PrestonLooper@adapt.us

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					Innovations	888.863.6808,ext. 3410
				Transicare	Scott Black, LMSW Chief Executive Officer	9304 Forest Lane, Suite 161 North, Dallas, Texas 75243 sblack@transicareinc.com 214.342.5800
				Homeward Bound	Douglas W. Denton, MA, LCDC, LCCA, ADS Executive Director	315 Sunset Ave. Dallas, TX 75208 ddenton@homewardboundinc.org 214.941.3500
Private hospital				Texas Scottish Rite Hospital	Scott Perryman, Senior Vice President	2222 Welborn Dallas, TX 75219 scott_perryman@tsrh.org 214.559.7608
Others (specify type, e.g. advocacy groups, associations)				Dallas-Fort Worth Hospital Council	Steve Love President and CEO	250 Decker Drive Irving, TX 75062 slove@dfwhc.org 972.719.4900
				Dallas Medical Resources	Margaret Jordan President and CEO	Dallas, TX mjordangroup@gmail.com 214.520.6112

Section II. Executive Overview of RHP Plan

Section II. Executive Overview of RHP Plan

The organizations and individuals that comprise the Regional Healthcare Partnership for Region Nine have welcomed and invested deeply in the development of this plan to transform the healthcare delivery system serving RHP 9's three counties: Dallas, Denton and Kaufman. RHP 9 participants have spent countless hours considering the community's needs and challenges, understanding the goals of the 1115 Waiver demonstration, and developing concepts, vetting ideas and refining collaborative strategies that will best serve this region.

Summary of Existing RHP Healthcare Environment

RHP 9, consisting of Dallas, Denton and Kaufman counties has an estimated 2010 total population of 3,134,103[1], of which approximately 75 percent reside in Dallas County. In 2011, of the total population in the three counties, approximately 40 percent[2] (or 1.25 million) live at or below 200 percent of poverty. Of this low income population, approximately 85 percent reside in Dallas County. Accordingly, the Region Nine RHP serves the very large vulnerable population intended to be at the center of this transformational waiver program.

The North Texas health care delivery market is dominated by several large health systems. While the systems are expanding into growing suburban markets, they maintain major flagship hospitals in Dallas County. These continue to attract a large number of patients from surrounding counties and regions. RHP 9 health care system hospitals and physicians are increasingly working together to address development opportunities as accountable care organizations, prompting greater focus on care coordination and integration across the care continuum. Inclusion of the community mental health centers and local health departments as participants in the RHP 9 plan has yielded greater interface and collaboration among the entire region's performing providers.

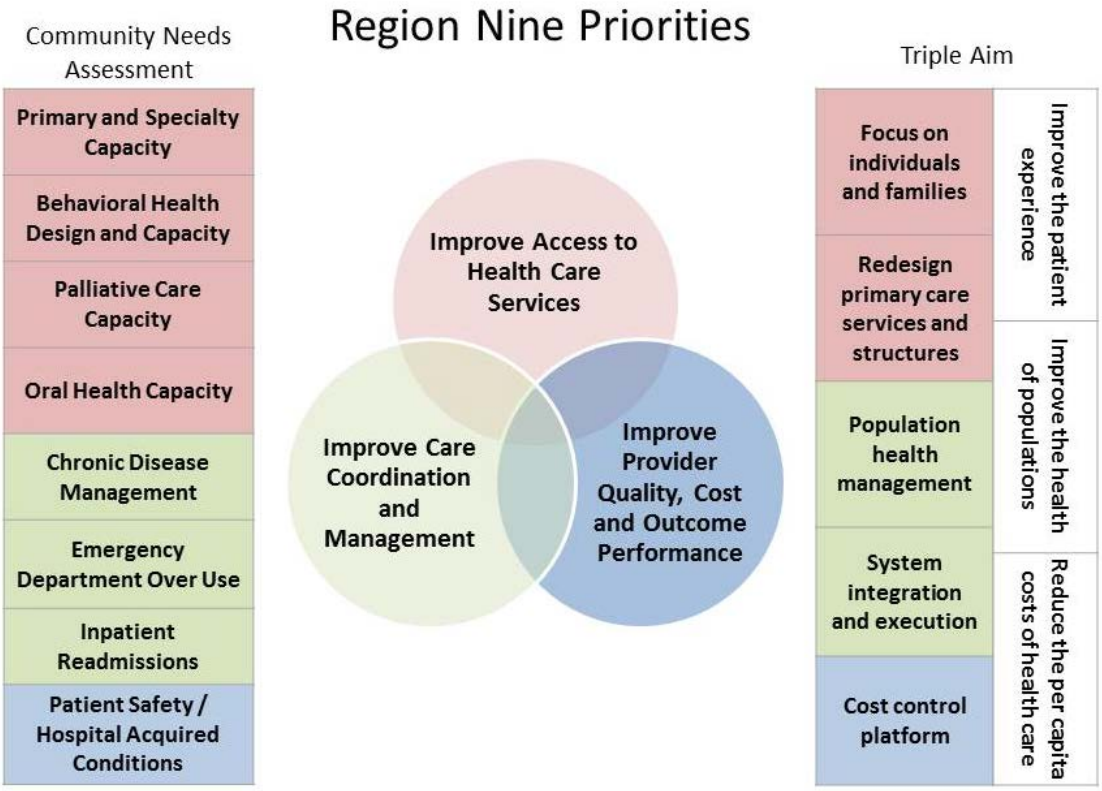
Under the direction of the Department of State Health Services, the NorthSTAR Program is a publicly funded managed care approach to the delivery of mental health and chemical dependency services to the eligible residents of Dallas, Ellis, Collin, Hunt, Navarro, Rockwall and Kaufman counties. The North Texas Behavioral Health Authority (NTBHA) serves as the local behavioral health (mental health and substance abuse) authority for the entire NorthSTAR service area and functions as the planning, oversight, and single portal authority. As presently structured, the NorthSTAR program is unable to serve as an IGT funding source for behavioral health programs. This has greatly limited the ability to have behavioral health DSRIP projects in Dallas County. Although unable to participate directly, the leaders of NorthSTAR and its behavioral health providers have been actively engaged in the plan development. Anticipating that NorthSTAR may be able to effect structural changes in its funding during the upcoming

[1] U.S. Census Bureau
[2] U.S. Census Bureau, American Fact Finder, Poverty Status in the Past Twelve Months, 2011

Texas legislative session, the RHP 9 participants have agreed to reserve funding allocation for NorthSTAR participation through a future plan modification.

RHP 9 Priorities

The following schematic presents the factors that frame the Region Nine focus for transformational change. Bracing on one side the challenges that were identified in the Community Needs Assessment and on the other side the intentions of the Texas Healthcare Transformation and Quality Improvement Program embodied by the Triple Aim, RHP 9 has identified three broad priorities for transformation. Each of the region's DSRIP projects addresses one or more of the priorities. Collectively, the projects that make up our plan will make significant strides in meeting the three priorities.



By designing and implementing projects that improve access to health care services, improve the coordination and management of care to the individual patient across the continuum, and improve the quality, cost and outcome performance of the region's health system providers, RHP 9 participants believe that we will address the community needs and advance the region with respect to the Triple Aim.

Key Challenges Facing the RHP

The size and density of the low-income population creates an enormous disparity between demand for and supply of services. This plan has a number of DSRIP projects that will contribute to the growth and development of healthcare service capacity. To maximize the impact of the projects that will grow capacity, the region must also obtain maximum utility from the projects designed for care coordination and care management interventions. Additionally, the plan development process used for the RHP 9 plan has has sparked a new and productive forum for collaboration and learning. RHP 9 will establish a robust post-implementation process to assure that the investment made in this plan will achieve maximal gains for the individual performing providers and for the region.

DSRIP Project Alignment with RHP 9 Priorities

The following graph presents the alignment of RHP 9 projects with the region's priority goals.

Summary of RHP 9 Projects Aligned with Plan Goals
Categories 1 and 2 Projects

See Appendix A for the detail that supports this graphic presentation.

While a little more than one third (34 percent) of the RHP 9 project investments relate to improving access to care, nearly half (46 percent) address assuring that the region's interventions are directed to coordinating the health system resources for the benefit of the individual patient. And 20 percent of the Region's project value is directed to strengthening the performance of the region's providers so that they can support and fulfill the region's goals.

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			
195018001.1.1 Establish more primary care clinics Baylor Medical Center Carrollton (Trinity Medical Center) 195018001	1.1.1 - Establish new clinic for underserved patients in the Carrollton area on the Baylor Carrollton campus.	IT- 1.7 Controlling high blood pressure (NQF 0018) (Stand-alone Measure) IT- 6.1 Percent improvement over baseline of patient satisfaction scores: (Standalone Measure) timely care, appointments, and information (wait times in clinic) IT- 6.1 Percent improvement over baseline of patient satisfaction scores: (Standalone Measure) timely care, appointments, and information (response time to patient phone calls) IT- 12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure) IT- 12.5 Other USPSTF-endorsed screening outcome measure (Non-standalone measure) - Influenza Vaccination Rate	$1,173,530
195018001.1.2 Expand Specialty Care Baylor Medical Center at Carrollton (Trinity Medical Center) 195018001	1.9.2 - Increase access to specialty care services in the Garland area	IT- 12.2 Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure) IT- 12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure) IT-11.1 Improvement in disparate health outcome for target population including identification of disparate gap	$244,485
121790303.1.1 Expand Primary Care Capacity Baylor Medical Center at Garland 121790303	1.1.2 - Expand current primary care capacity in the Garland area by opening provider panels to non-Baylor indigent/low income patients	IT- 1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)-Standalone Measure IT- 6.1 Percent improvement over baseline of patient satisfaction scores: (Standalone Measure) timely care, appointments, and information (wait	$1,753,656

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**
		times in clinic) IT- 6.1 Percent improvement over baseline of patient satisfaction scores: (Standalone Measure) timely care, appointments, and information (response time to patient phone calls) IT- 12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure) IT- 12.5 Other USPSTF-endorsed screening outcome measures (Non-standalone measure)- Influenza Vaccination Rate	
121790303.1.2 Expand Specialty Care Capacity Baylor Medical Center at Garland 121790303	1.9.2 - Increase access to specialty care services in the Garland area	IT- 11.1 Improvement in Clinical Indicator in identified disparity group. (Standalone measure) -Improvement in Asthma IT- 12.2 Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure) IT- 12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)	$1,553,239
121776204.1.1 Expand Primary Care Capacity Baylor Medical Center at Irving 121776204	1.1.2 - Expand current primary care capacity in the Irving area by opening provider panels to non-Baylor indigent/low income patients	IT- 1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Stand-alone Measure) IT- 6.1 Percent improvement over baseline of patient satisfaction scores: (Standalone Measure) timely care, appointments, and information (wait times in clinic) IT- 6.1 Percent improvement over baseline of patient satisfaction scores: (Standalone Measure) timely care, appointments, and information (response time to patient phone calls) IT- 12.1 Breast Cancer Screening (HEDIS	$1,497,432

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**
		2012) (Non-standalone measure) IT- 12.5 Other USPSTF-endorsed screening outcome measures (Non-standalone measure) - Influenza Vaccination Rate	
121776204.1.2 Expand Specialty Care Capacity Baylor Medical Center at Irving 121776204	1.9.2. - Increase access to specialty care services in the Garland area	IT- 11.1 Improvement in Clinical Indicator in identified disparity group. (Standalone measure) - Improvement in Asthma IT- 12.2 Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure) IT- 12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)	$1,228,661
139485012.1.1 Expand primary care capacity Baylor University Medical Center 139485012	1.1.2 - Expand current primary care capacity by opening provider panels to non-Baylor indigent/low income patients	IT- 1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)- Standalone Measure IT- 6.1 Percent improvement over baseline of patient satisfaction scores: (Standalone Measure) timely care, appointments, and information (wait times in clinic) IT- 6.1 Percent improvement over baseline of patient satisfaction scores: (Standalone Measure) timely care, appointments, and information (response time to patient phone calls) IT- 12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure) IT- 12.5 Other USPSTF-endorsed screening outcome measures (Non-standalone measure) - Influenza Vaccination Rate	$8,414,068

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**
139485012.1.2 Expand Specialty Care Capacity Baylor University Medical Center 139485012	1.9.2 - Increase access to specialty care services	11.1 Improvement in Clinical Indicator in identified disparity group. (Standalone measure) - Improvement in Asthma IT- 12.2 Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure) IT- 12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)	$7,281,405
138910807.1.1 Expand Primary Care Capacity Children's Medical Center of Dallas 138910807	1.1.1 - Expand capacity of pediatric primary care in Dallas County by opening 7 clinics that provide medical homes for children w/complex chronic illness	IT-9.2 ED Appropriate Utilization	$13,058,942
138910807.1.2 Expand Primary Care Capacity Children's Medical Center of Dallas 138910807	1.1.2 - Expand pediatric primary care capacity in Dallas County by expanding clinic hours and staffing	IT-9.2 ED Appropriate Utilization	$12,054,408
138910807.1.3 Implement Chronic Disease Management Registry Children's Medical Center of Dallas 138910807	1.3.1 - Expand CMC-certified disease management programs capacity to treat more patients and to provide infrastructure needed to accomplish standardized chronic illness management	IT-2.13 Other Readmission Rate	$12,054,408

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138910807.1.4 Enhance service availability to appropriate levels of behavioral health Children's Medical Center of Dallas 138910807	1.12.2 - Expand pediatric behavioral health capacity in CMC primary care settings to align and coordinate care for behavioral and medical illnesses	IT-1.20 Other Outcome Measure	$12,054,408
121758005.1.1 Develop behavioral health crisis stabilization services Dallas County Health and Human Services 121758005	1.13.1 - Establish a community-based behavioral Health crisis stabilization program in Dallas County	IT-9.1 Decrease in Mental Health Admissions and Readmissions to Criminal Justice Settings IT-9.2 ED Appropriate Utilization (Stand-alone Measure	$17,642,792
137252607.1.1 Workforce Enhancement to improve behavioral health access Dallas County MHMR Center d/b/a Metrocare Services 137252607	1.14.2 – Increase number of behavioral health residents and others trained in a community mental health setting to reduce shortage of behavioral health providers	IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions on survey must be answered to be a Stand-alone Measure)	$1,595,363
137252607.1.2 – Pass 2 Expand Behavioral Health Outpatient Services for Children, Adults and Families Dallas County MHMR Center d/b/a Metrocare Services 137252607	1.12.2 - Expand number of community-based settings in underserved areas were behavioral health services may be delivered	IT-10.1 Quality of Life/Functional Status	$6,812,396
121988304.1.1 Develop behavioral health crisis stabilization services Lakes Regional MHMR Center 121988304	1.13.1 - Develop community-based behavioral health crisis stabilization services	IT-6.1 Percent Improvement over baseline of patient satisfaction scores (all questions on survey must be answered to be a Stand-alone Measure)	$6,421,691

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121988304.1.2 Introduce Telemedicine/ Telehealth – Beh. Health Lakes Regional MHMR Center 121988304	1.7.1 - Implement telehealth behavioral health care service for low income patients in rural areas in/around Kaufman County	IT-6.1 Percent Improvement over baseline of patient satisfaction scores (all questions on survey must be answered to be a Stand-alone Measure)	$1,791,134
020943901.1.1 Expand, Telemedicine/ Telehealth – Stroke Medical City Dallas Hospital 020943901	1.7.1 - Align regional hospitals that form a stroke care system whereby facilities gain immediate access to vascular neurologists via telehealth network	IT-4.10 Treatment Rate Ischemic Stroke (IV t-PA/endovascular intervention) IT-4.10 Other - Average Length of Stay - Ischemic Stroke patients IT-4.10 Other - Door To Needle time for IV t-PA administration	$5,174,491
020943901.1.2 Introduce, Expand, Enhance Telemedicine/Telehealth – Behavioral Health Medical City Dallas Hospital 020943901	1.7.1 - Implement telemedicine program with psychiatric specialists at Green Oaks Hospital for consult, evaluation and treatment of patients at remote sites/hospitals	IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate (Stand-alone Measure)	$3,606,157
020943901.1.3 Expand Primary Care Capacity Medical City Dallas Hospital 020943901	1.1.1 - Partner with PediPlace (nonprofit organization) to establish a pediatric primary care outpatient clinic for Medicaid/ CHIP and uninsured patients in North Dallas	IT-9.3 Pediatric/Young Adult Asthma Emergency Room Visits (NQF 1381) (Stand-alone Measure)	$3,521,529
127295703.1.1 Establish more primary care clinics – Grand Prairie Parkland Health & Hospital System 127295703	1.1.2 - Expand primary care capacity for low income/indigent patients by ramping up new Community Oriented Primary Care clinic in Grand Prairie area in Dallas County	IT-1.2 Annual monitoring of patients on persistent medications – angiotensin converting enzyme (ACE inhibitors) or angiotensin receptor blockers (ARBs) (Non-standalone Measure) IT-1.12 Diabetes: Retinal Eye Exam (NQF 0055) (Non-standalone Measure)	$29,017,613

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		IT-1.20 Other: % patients who by age 13 were up-to-date with recommended adolescent immunizations: MCVS, Tdap	
127295703.1.2 Expand current primary care capacity Parkland Health & Hospital System 127295703	1.1.2 - Expand primary care capacity for low income/indigent patients throughout the Parkland network of primary care sites through various methods including expanding hours, staff and space	IT-1.2 Annual monitoring of patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE inhibitors) or angiotensin receptor blockers (ARBs) (Non-standalone Measure) IT-1.12 Diabetes: Retinal Eye Exam (NQF 0055) (Non-standalone Measure) IT-1.20 Other: % patients who by age 13 were up-to-date with recommended adolescent immunizations: MCVS, Tdap	$20,598,923
127295703.1.3 Implement chronic care disease registry Parkland Health & Hospital System 127295703	1.3.1 - Implement a chronic disease management registry to assist with implementation of a chronic care/disease management model	IT-1.2 Annual monitoring of patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE inhibitors) or angiotensin receptor blockers (ARBs) (Non-standalone Measure) IT-1.12 Diabetes: Retinal Eye Exam (NQF 0055) (Non-standalone Measure) IT-3.3 Diabetes 30-Day Readmission Rate (Stand-alone Measure)	$27,405,524
127295703.1.4 Enhance performance improvement and reporting capacity Parkland Health & Hospital System 127295703	1.10.4 – Implement the Quality Through Transformation Initiative	IT-9.2 ED Appropriate Utilization	$30,808,824

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127295703.1.5 Expand specialty care capacity Parkland Health & Hospital System 127295703	1.9.2 – Expand specialty care access	IT-1.1 Third next available appointment IT-9.2 ED Appropriate Utilization	$23,285,739
127295703.1.6 – Pass 2 Establish more primary care clinics – Acute Response Clinic(s) Parkland Health & Hospital System 127295703.6	1.1.1 – Develop Acute Response Clinic	IT-3.1 All Cause 30-day Readmission Rate	$29,375,855
127295703.1.7 – Pass 2 Enhance Interpretation Services Parkland Health & Hospital System 127295703	1.4.7 – Other: Implement Health Literate Care Model and Enhance Interpretation Services	IT-6.1 Percent improvement over baseline for patient satisfaction scores	$26,689,039
009784201.1.1 Expansion of Senior Dental Student Externship Program Texas A&M Health Science Center / Baylor College of Dentistry 009784201	1.8.1 - Develop academic linkages with three Texas dental schools to establish a multi-week externship program for fourth year dental students	IT-7.10 Other Outcome Improvement Target: Percentage of class participating in externship program	$2,657,811
009784201.1.2 Expansion of Dallas County dental clinics Texas A&M Health Science Center / Baylor College of Dentistry 009784201	1.8.6 – Expansion of services - dental clinic hours	IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on permanent first molar tooth. IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period	$10,502,323

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		IT-7.4 Topical Fluoride Application: Percentage of children 0-20 years who received a fluoride varnish application during the measurement period	
009784201.1.3 Expansion of school-based dental sealant program Texas A&M Health Science Center / Baylor College of Dentistry 009784201	1.8.9 – Expand school-based sealant and/or fluoride varnish programs	IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on permanent first molar tooth. IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period IT-7.4 Topical Fluoride Application: Percentage of children 0-20 years who received a fluoride varnish application during the measurement period	$2,722,572
020908201.1.1 Expand existing primary care capacity Texas Health Presbyterian Hospital Dallas 020908201	1.1.2 - The Continuing Care Clinic will be located in ED fast track area to provide an alternative lower level of care setting for urgent needs	IT-3.3 Diabetes 30-Day Readmission rate (Stand-alone measure) IT-3.10 Adult Asthma 30-Day Readmission Rate (Standalone measure) IT-9.2 ED Appropriate Utilization (Stand-alone measure)	$5,494,653
126686802.1.1 Establish more primary care clinics UT Southwestern Medical Center – Faculty Practice Plan 126686802	1.1.1 - Establish primary care clinic co-located with specialty care clinic	IT-12.1 Breast Cancer Screening (Non-standalone Measure) IT-12.3 Colorectal Cancer Screening (Non-standalone Measure) IT-12.4 Pneumonia vaccination status of older adults (Non-standalone Measure)	$8,821,395

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126686802.1.2 Expand Primary Care Capacity UT Southwestern Medical Center – Faculty Practice Plan 126686802	1.1.2 - Expand primary care capacity within the UTSCAP network	IT-12.1 Breast Cancer Screening (Non-standalone Measure) IT-12.3 Colorectal Cancer Screening (NSA) IT-12.4 Pneumonia vaccination status of older adults (Non-standalone Measure)	$14,996,373
126686802.1.3 Expand Primary Care Capacity UT Southwestern Medical Center – Faculty Practice Plan 126686802	1.1.4 - Implement quality incentive program for primary care providers	IT-12.1 Breast Cancer Screening (Non-standalone Measure) IT-12.3 Colorectal Cancer Screening (Non-standalone Measure) IT-12.4 Pneumonia vaccination status of older adults (Non-standalone Measure)	$17,201,722
126686802.1.4 Introduce, Expand, or Enhance Telemedicine/Telehealth UT Southwestern Medical Center – Faculty Practice Plan 126686802	1.7.1 - Introduce telehealth network	IT-1.6 Cholesterol Management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Stand-alone Measure) IT-1.7 Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (SA) IT-1.10 Diabetes care: HbA1c poor control (>9.0%) (NQF 0059) (Stand-alone Measure)	$15,878,512
126686802.1.5 Expand Specialty Care Capacity UT Southwestern Medical Center – Faculty Practice Plan 126686802	1.9.2 - Establish specialty care clinic co-located with primary care	IT-1.6 Cholesterol Management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Stand-alone Measure) IT-1.7 Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Stand-alone Measure)	$10,144,606

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126686802.1.6 Enhance Performance Improvement and Reporting Capacity UT Southwestern Medical Center – Faculty Practice Plan 126686802	1.10.2 – Enhance improvement capacity through technology	IT-12.1 Breast Cancer Screening (Non-standalone Measure) IT-12.3 Colorectal Cancer Screening (Non-standalone Measure IT-12.4 Pneumonia vaccination status of older adults (Non-standalone Measure) IT-1.10 Diabetes Care: HbA1c poor control	$11,908,885
126686802.1.7 – Pass 2 Increase training of Primary Care Workforce UT Southwestern Medical Center – Faculty Practice Plan 126686802	1.2.1 - Increase training of primary care workforce	IT-1.20 Number of primary care practitioners in HPSAs or MUAs who report they plan to implement chronic disease management	$7,467,369
126686802.1.8 – Pass 2 Increase Training of Primary Care Workforce UT Southwestern Medical Center – Faculty Practice Plan 126686802	1.2.1 - Inrease training of Family Medicine residents in Patient-Centered Medical Home and Chronic Disease Management	IT-14.1 Number of practicing primary care practitioners per 1000 individuals in HPSAs or MUAs	$4,910,295
126686802.1.9 – Pass 2 Expansion and Redesign of UTSW Physician Assistant Program UT Southwestern Medical Center – Faculty Practice Plan 126686802	1.2.2 - Expansion and Redesign of UTSW Physician Assistant Program	IT-14.2 Number of practicing nurse practioners and physician assistants per 1,000 individuals in HPSAs or MUAs	$9,239,332

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126686802.1.10 – Pass 2 Training of Community Health Workers UT Southwestern Medical Center – Faculty Practice Plan 126686802	1.2.2 - Training of Community Health Workers	IT-1.7 Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Stand-alone Measure)	$7,360,599
126686802.1.11 – Pass 2 Establish and Expand Urgent Care Services for Cancer Patients UT Southwestern Medical Center – Faculty Practice Plan 126686802	1.9.2 - Establish and expand urgent care services for cancer patients	IT-2.13 Other Admission Rate (complications of cancer treatment) IT-9.2 ED Appropriate Utilization	$10,918,064
126686802.1.12 – Pass 2 Enhance Performance Improvement and Reporting Capacity UT Southwestern Medical Center – Faculty Practice Plan 126686802	1.10.2 – Enhance Performance Improvement and Reporting Capacity through development of quality data management and systems engineering group/function	IT-3.1 All Cause 30-day Readmission Rate	$10,881,242
175287501.1.1 – Pass 2 Expand specialty care capacity UT Southwestern Medical Center - St. Paul University Hospital 175287501	1.9.3 - Expand specialty care capacity by providing access to bone marrow and solid organ transplants for patients with inadequate funding	IT-1.20 Other outcomes improvement target. Outcomes of bone marrow and solid organ transplantation IT-4.2 Central Line-Associated Bloodstream (CLABSI) Rate	$11,749,722

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Category 2: Program Innovation and Redesign			
195018001.2.1 Expand Chronic Care Management Models Baylor Medical Center at Carrollton (Trinity Medical Center) 195018001	2.2.2 - Establish chronic care management program to provide focused and dedicated education and care for patients with diabetes, cardiovascular, and respiratory disease w/in primary care setting	IT-1.10 Diabetes: HbA1c poor control (>9.0%) (NQF 0059) (Stand-alone measure) IT-1.11 Diabetes: BP control (<140/ 80mm Hg) (NQF 0061) (Stand-alone measure) IT-1.13 Diabetes: Foot exam (NQF 0056) (Non-standalone measure)	$447,059
121790303.2.1 Expand Chronic Care Management Model - Create Chronic Disease management and Prevention Program Baylor Medical Center at Garland 121790303	2.2.2 - Establish a chronic care management program to provide education and care for patients w/ diabetes, cardiovascular disease and respiratory disease within a primary care setting	IT-1.10 Diabetes: HbA1c poor control (>9.0%) (NQF 0059) (Standalone measure) IT-1.11 Diabetes: BP control (<140/ 80mm Hg) (NQF 0061) (Standalone measure) IT-1.13 Diabetes: Foot exam (NQF 0056) (Non- standalone measure)	$1,628,396
121790303.2.2 Develop Care Management Function that integrates primary and behavioral health needs of individuals Baylor Medical Center at Garland 121790303	2.19.1 - Co-locate and integrate behavioral health into the primary care setting at Baylor Medical Center at Garland	IT-11.1 Improvement in Clinical Indicator in identified disparity group.(Standalone measure) - Improvement in Diabetes IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure) - Improve behavioral health treatment rates	$1,553,239

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121790303.2.3 Establish/Expand a Patient Care Navigation Program Baylor Medical Center at Garland 121790303	2.9.1 - Create a fluid patient navigation program located at Baylor Medical Center of Garland ER for patients identified as not having a primary care physician and/or a medical home	IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (Standalone measure for Project 2.5 only) IT-9.2 ED appropriate utilization (Standalone measure)	$1,540,714
121790303.2.4 – Pass 2 Pilot intervention(s) in Care Transitions – Home Visit Program Baylor Medical Center at Garland 121790303	2.12.2 - Pilot intervention(s) in Care Transitions targeting defined patient population – early followup – Vulnerable Patient Network (Home Visit Program)	IT-10.1 Quality of Life (Standalone Measure) IT-10.2: Activities of Daily Living (Standalone Measure)	$1,029,021
121790303.2.5 – Pass 2 Other: Medication Management and Prescription Assistance Program Baylor Medical Center at Garland 121790303	2.11.3 - Evidence-based interventions - teams, techonology and processes - to to insure medication compliance and management	IT-1.2 Annual monitoring of patients on persistent medications – ACE inhibitors/ ARBSs (Non-standalone Measure) IT-1.4 Annual monitoring of patients on persistent medications – diuretics (Non-standalone Measure) IT-1.5 Annual monitoring of patients on persistent medications – anticonvulsants (Non-standalone Measure) IT-1.19 Anti-depressant Medication Management (Standalone Measure)	$912,528
121776204.2.1 Expand Chronic Care Management Models Baylor Medical Center at Irving 121776204	2.2.2 - Establish chronic care management program in primary care setting to provide education and care for patients w/ diabetes, cardiovascular disease and respiratory disease	IT-1.10 Diabetes: HbA1c poor control (>9.0%) (NQF 0059) (Standalone measure) IT-1.11 Diabetes: BP control (<140/ 80mm Hg) (NQF 0061) (Standalone measure)	$1,267,057

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		IT-1.13 Diabetes: Foot exam(NQF 0056) (Non- standalone measure)	
121776204.2.2 Develop a Care Management function that integrates primary and behavioral health needs of individuals Baylor Medical Center at Irving 121776204	2.19.1 - Co-locate and integrate behavioral health into the primary care setting at Baylor Medical Center of Irving	IT-11.1 Improvement in Clinical Indicator in identified disparity group. (Standalone measure) - Improvement in Diabetes IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure) - Improvement in behavioral health treatment rates	$1,087,877
121776204.2.3 Establish/Expand a Patient Care Navigation Program Baylor Medical Center at Irving 121776204	2.9.1 - Create a fluid patient navigation program in ER for patients identified as not having a primary care physician and/or a medical home	IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (Non- standalone measure) IT-9.2 ED appropriate utilization (Standalone measure)	$1,087,877
121776204.2.4 – Pass 2 Pilot intervention in Care Transitions - Home Visits Baylor Medical Center at Irving 121776204	2.12.2 - Pilot in Care Transitions targeting defined population – early followup – Vulnerable Patient Network (Home Visit Program)	IT-10.1 Quality of Life (Standalone Measure) IT-10.2: Activities of Daily Living (Standalone Measure)	$1,024,269
121776204.2.5 – Pass 2 Other: Medication Management and Prescription Assistance Program Baylor Medical Center at Irving 121776204	2.11.3 - Evidence-based interventions - teams, techonology and processes - to to insure medication compliance and management	IT-1.2 Annual monitoring of patients on persistent medications – ACE inhibitors/ ARBSs (Non-standalone Measure) IT-1.4 Annual monitoring of patients on persistent medications – diuretics (Non-standalone Measure)	$908,313

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		IT-1.5 Annual monitoring of patients on persistent medications – anti-convulsants (Non-standalone Measure) IT-1.19 Anti-depressant Medication Management (Standalone Measure)	
139485012.2.1 Expand Chronic Care Management Models Baylor University Medical Center 139485012	2.2.2 - Establish a chronic care management program to provide focused and dedicated education and care for patients with diabetes, cardiovascular or respiratory disease in primary care setting	IT-1.10 Diabetes: HbA1c poor control (>9.0%) (NQF 0059) (Standalone measure) IT-1.11 Diabetes: BP control (<140/80mm Hg) (NQF 0061) (Standalone measure) IT-1.13 Diabetes: Foot exam (NQF 0056) (Non- standalone measure)	$7,658,960
139485012.2.2 Develop Care Management Function that integrates primary and behavioral health needs of individuals Baylor University Medical Center 139485012	2.19.1 - Co-locate and integrate behavioral health into the primary care setting – provide services including behavioral health counseling, screening, treatment	IT-11.1 Improvement in Clinical Indicator in identified disparity group. (Standalone measure) - Improvement in Diabetes IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (NSA) – Improvement in behavioral health treatment rates	$7,497,150
139485012.2.3 Establish/Expand a Patient Care Navigation Program Baylor University Medical Center 139485012	2.9.1 - Expand patient navigation program (Care Connect) for patients identified as not having a primary care physician and/or a medical home	IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (Non- standalone measure) IT-9.2 ED Appropriate Utilization (Standalone measure)	$7,281,405

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139485012.2.4 – Pass 2 Pilot intervention(s) in Care Transitions – Home Visit Program Baylor University Medical Center 139485012	2.12.2 - Pilot intervention(s) in Care Transitions targeting defined patient population – early followup – Vulnerable Patient Network (Home Visit Program)	IT-10.1 Quality of Life (Standalone Measure) IT-10.2: Activities of Daily Living (Standalone Measure)	$4,602,388
139485012.2.5 – Pass 2 Other: Medication Management and Prescription Assistance Program Baylor University Medical Center 139485012	2.11.3 - Evidence-based interventions - teams, techonology and processes - to to insure medication compliance and management	IT-1.2 Annual monitoring of patients on persistent medications – ACE inhibitors/ ARBSs (Non-standalone Measure) IT-1.4 Annual monitoring of patients on persistent medications – diuretics (Non-standalone Measure) IT-1.5 Annual monitoring of patients on persistent medications – anticonvulsants (Non-standalone Measure) IT-1.19 Anti-depressant Medication Management (Standalone Measure)	$4,081,362
138910807.2.1 Enhance/Expand Medical Homes Children's Medical Center of Dallas 138910807	2.1.1 - Develop, implement and spread across Children's Medical Center pediatric primary care centers a medical home team-based approach to care	IT-9.2 ED Appropriate Utilization	$15,068,009
138910807.2.2 Implement Evidence-based Health Promotion Program Children's Medical Center of Dallas 138910807	2.6.1 - Integrate fragmented individual community health improvement activities into organized set of evidence-based interventions for conditions such as asthma and diabetes	IT-9.3 Pediaric and Young Adult Asthma Emergency Visits	$13,058,941

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138910807.2.3 Establish/Expand a Patient Care Navigation Program Children's Medical Center of Dallas 138910807	2.9.1 - Utilize high-intensity, culturally appropriate care management system for Medicaid and safety net children and families	IT-9.2 ED Appropriate Utilization	$13,058,942
138910807.2.4 Implement/Expand Care Transitions Programs Children's Medical Center of Dallas 138910807	2.12.2 - Develop standardized approach to transition adolescents with special health needs or at risk for loss of medical services;	IT-9.2 ED Appropriate Utilization	$10,033,464
121758005.2.1 Disease Outbreaks and Sentinel Events Health Education Dallas County Health and Human Services 121758005	2.6.2 Establish self-management programs and wellness using evidence-based designs	IT-11.2 Improvement in disparate health outcomes for target population, including identification of the disparity gap (NSA) IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (NSA) IT-12.5 Other USPSTF-endorsed screening outcome measure	$623,230
121758005.2.2 STD, TB, Immunizations - Health Education Dallas County Health and Human Services 121758005	2.6.2 Establish self-management programs and wellness using evidence-based designs	IT-11.2 Improvement in disparate health outcomes for target population, including identification of the disparity gap (NSA) IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (NSA) IT-12.5 Other USPSTF-endorsed screening outcome measure	$1,548,089

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137252607.2.1 Integrate Primary and Behavioral Health Services Dallas County MHMR Center d/b/a Metrocare Services 137252607	2.15.1 - Provide integrated model of open access to primary care services for mental health patients.	IT-1.7 Controlling high blood pressure	$4,317,743
137252607.2.2 Intervention for a targeted behavioral health population to prevent unnecessary use of services – ACT Dallas County MHMR Center d/b/a Metrocare Services 137252607	2.13.1 – Utilize Behavior Treatment Services Assertive Community Wrap-around Treatment Team (ACT) to be on-call to travel to an acute care facility, jail or school to assess and stabilize situation and provide follow up behavioral health services as appropriate	IT-10.1 Quality of Life	$1,291,504
137252607.2.3 Intervention for a behavioral health population to prevent unnecessary use of services – Family Preservation Dallas County MHMR Center d/b/a Metrocare Services 137252607	2.13.1 - Establish Family Preservation Program - short-term intensive program for medication management, case management and counseling to young patients discharged from psychiatric facilities and/or those at risk for out-of-home placement	IT-10.1 Quality of Life	$2,702,056

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137252607.2.4 Intervention for targeted behavioral health population to prevent unnecessary use of services – Center for Children with Autism Dallas County MHMR Center d/b/a Metrocare Services 137252607	2.13.1 - The Center for Children with Autism will provide 1:1 applied behavior analysis to children with on the autism spectrum and/or children with other developmental disabilities	IT-9.4 Other Outcome Improvement Target – Reduce intensive school services and out-of-home treatment Episodes IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions of survey must be answered to be stand-alone measure)	$2,838,600
137252607.2.5 Intervention for a targeted behavioral health population to prevent unnecessary use of services– Day Program Dallas County MHMR Center d/b/a Metrocare Services 137252607	2.13.1 - The Behavioral Health Day Program will provide short-term behavioral intervention, crisis diversion and urgent safety net services for individuals with intellectual and developmental disabilities	IT-10.1 Quality of Life	$2,968,053
136360803.2.1 Expand Chronic Care Management Models Denton County Health and Human Services 136360803	2.2.1 - Establish team-based chronic management approach, incorporating components of the Wagner Chronic Care Model. Develop/utilize a diabetes registry (Denton County)	IT-1.10 Diabetes: HbA1c poor control > 9.0% (NQF 0059) (Stand-alone Measure)	$4,410,698
136360803.2.2 Implement Evidence-based Disease Prevention Programs Denton County Health and Human Services 136360803	2.7.6 - Target low income Denton County Health Clinic adult patients to receive vaccines to help them stay healthy, stay on the job, and prevent disease, hospitalization	IT-2.10 Flu and Pneumonia Admissions Rate (Stand-alone Measure)	$4,410,698

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**
135234606.2.1 Process Improvement Methodology Denton County MHMR Center 135234606	2.8.6 - Establish 24-hour psychiatric triage facility to better accommodate high demand for psychiatric triage services, and to reduce inappropriate ED utilization	IT-9.2 ED Appropriate Utilization (Stand-alone Measure)	$11,090,221
135234606.2.2 Integrate Primary and Behavioral Health Care Services Denton County MHMR Center 135234606	2.15.1 - Integrate care management functions for individuals with co-morbid chronic diseases, mental illness, and/or substance use disorders, through collaborative partnership agreements	IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions on survey must be answered to be a stand-alone measure)	$5,238,202
135234606.2.3 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in specified setting Denton County MHMR Center 135234606	2.13.1 - Increase capacity for crisis residential services to better accommodate the high demand for crisis residential services and reduce potentially preventable admissions and readmissions to hospitals and jails	IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions on survey must be answered to be a stand-alone measure)	$8,710,400
111905902.2.1 Process Improvement Methodology to Improve Quality and Efficiency – Sepsis Denton Regional Medical Center 111905902	2.8.11 - Design and implement a Process Improvement plan to increase the utilization and compliance with Sepsis Resuscitation and Management Bundles and improve outcomes	IT-4.8 Sepsis mortality (Stand-alone Measure) IT-4.9 Average length of stay (Non-standalone Measure)	$1,370,117

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**
111905902.2.2 Redesign to Improve Patient Experience Denton Regional Medical Center 111905902	2.4.1 - Establish baseline HCAHPS scores and implement patient/ family experience strategic plan	IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions on survey must be answered to be a stand-alone measure)	$1,934,127
094194002.2.1 – Pass 2 Enhance/Expand Medical Home Model – Mission East Dallas Doctors Hospital at White Rock Lake (Tenet) 094194002	2.1.2 – Collaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients	IT-12.2 Cervical cancer screening IT-1.10 Diabetes Care: HbA1c poor control (<9.0%)	$2,555,600
094194002.2.2 – Pass 2 Implement/Expand Care Transitions Program Doctors Hospital at White Rock Lake (Tenet) 094194002	2.12.1-Implement care transitions program targeting patients with highest risk of readmissions	IT-1.10 Diabetes Care: HbA1c poor control (<9.0%)	$613,900
121988304.2.1 – Pass 2 Intervention for targeted behavioral health population to prevent unnecessary use of services in specified setting Lakes Regional MHMR Center 121988304	2.13.1 - Design, implement and evaluate research-supported and evidence-based interventions tailored towards target population – Lakes Regional Cognitive Enhancement Therapy	IT-6.1 Patient Satisfaction	$3,490,488

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**
020979301.2.1 Redesign to Improve Patient Experience Las Colinas Medical Center 020979301	2.4.1 - Establish baseline HCAHPS scores and implement patient/ family experience strategic plan	IT-6.1 Percent Improvement over baseline of patient satisfaction scores (all questions on survey must be answered to be a stand-alone measure)	$657,118
094192402.2.1 Redesign to Improve Patient Experience Medical Center of Lewisville 094192402	2.4.1 - Establish baseline HCAHPS scores and implement patient/ family experience strategic plan	IT-6.1 Percent Improvement over baseline of patient satisfaction scores (all questions on survey must be answered to be a stand-alone measure)	$849,981
094192402.2.2 Process Improvement Methodology to Improve Quality and Efficiency – Sepsis Medical Center of Lewisville 094192402	2.8.11 - Design and implement a Process Improvement plan to increase the utilization and compliance with Sepsis Resuscitation and Management Bundles and improve patient outcomes	IT-4.8 Sepsis mortality (Stand-alone Measure) IT-4.9 Average length of stay (Non-standalone Measure)	$1,923,053
094192402.2.3 Establish/Expand a Patient Care Navigation Program Medical Center of Lewisville 094192402	2.9.1 - Implement patient care navigation program (patient assessment, case management, health literacy/ education, psychosocial support, and self-management education and support	IT-9.2 ED appropriate utilization (Stand-alone Measure)	$751,402
020943901.2.1 Integrate Primary and Behavioral Health Services Medical City Dallas Hospital 020943901	2.15.1 - Partner with Green Oaks Hospital to establish integrated primary and behavioral health clinic for patients receiving OP psychiatric care	IT-2.4 Behavioral Health/Substance Abuse Admission Rate IT-3.8 Behavioral Health/Substance Abuse 30-Day Readmission Rate	$3,901,150

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**
020943901.2.2 Project Withdrawn Medical City Dallas Hospital 020943901	Project Withdrawn	Project Withdrawn	$0
020943901.2.3 Process Improvement Methodology to Improve Quality and Efficiency – Sepsis Medical City Dallas Hospital 020943901	2.8.11 - Implement Process Improvement plan to increase the utilization and compliance with Sepsis Resuscitation and Management Bundles and improve patient outcomes	IT-4.8 Sepsis Mortality (Stand-alone Measure) IT-4.9 Average Length of Stay (Non-standalone Measure)	$3,753,964
020943901.2.4 – Pass 2 Enhance/Expand Medical Home Model at Metrocrest Clinic Medical City Dallas Hospital 020943901	2.1.1 - Establish a Medical Home at Metrocrest Clinic	IT-11.5 All Cause 30-day Readmission Rate	$3,007,899
126679303.2.1 Expand Chronic Disease Management Model Methodist Charlton Medical Center 126679303	2.2.2 - Apply evidence-based care management models for patients identified as having high-risk health care needs associated with diabetes	IT-1.11 Diabetes Control: Blood pressure control (<140/80mm Hg) IT-1.10 Diabetes Care: HbA1c poor control (>9.0%) (Stand-alone Measure) IT-3.3 Diabetes 30-day Readmission Rate (Stand-alone Measure)	$4,645,535
126679303.2.2 Expand patient care navigation program Methodist Charlton Medical Center 126679303	2.9.1 - Establish patient navigation services in the ED for high-risk patients or those identified as not having a primary care physician and/or medical home	IT-9.2 ED Utilization (Stand-alone Measure) IT-3.1 All cause 30-Day Readmission Rate (Stand-alone Measure)	$8,627,425

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**
135032405.2.1 Expand patient care navigation program Methodist Dallas Medical Center 135032405	2.9.1 - Establish patient navigation services in the ED for high-risk patients or those identified as not having a primary care physician and/or medical home	IT-3.1 All cause 30-Day Readmission Rate (Stand-alone Measure) IT-9.2 ED Utilization (Stand-alone Measure)	$14,383,398
135032405.2.2 Expand Chronic Disease Management Model Methodist Dallas Medical Center 135032405	2.2.2 - Apply evidence-based care management models for patients identified as having high-risk health care needs	IT-1.10 Diabetes Care: HbA1c poor control (>9.0%) (Stand-alone Measure) IT-1.11 Diabetes Control: Blood pressure control (<140/80mm Hg) IT-3.3 Diabetes 30-day Readmission Rate (Stand-alone Measure)	$7,321,539
135032405.2.3 – Pass 2 Enhance/ Expand Medical Home Model Methodist Dallas Medical Center 135032405	2.1.1 - Enhance/Expand Medical Home through charitable clinics	IT-11.5 All Cause 30-day Readmission Rate	$2,695,406
209345201.2.1 Expand patient care navigation program Methodist Richardson Medical Center 209345201	2.9.1 - Establish patient navigation services in the ED for high-risk patients or those identified as not having a primary care physician and/or medical home	IT-3.1 All cause 30-Day Readmission Rate (Stand-alone Measure) IT-9.2 ED Utilization (Stand-alone Measure)	$3,082,751
209345201.2.2 Expand Chronic Disease Management Model Methodist Richardson Medical Center 209345201	2.2.1 - Apply evidence-based care management models for patients identified as having high-risk health care needs associated with diabetes	IT-1.10 Diabetes Care: HbA1c poor control (>9.0%) (Stand-alone Measure) IT-1.11 Diabetes Control: Blood pressure control (<140/80mm Hg) IT-3.3 Diabetes 30-day Readmission Rate (Stand-alone Measure)	$2,055,166

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**
127295703.2.1 Expand Medical Home Model Parkland Health & Hospital System 127295703	2.1.1. - Expand the medical home model through PCMH recertification for the COPC primary care clinics	IT-1.2 Annual monitoring of patients on persistent medications – ACE inhibitors/ ARBs (Non-standalone Measure) IT-1.12 Diabetes: Retinal Eye Exam (NQF 0055) (Non-standalone Measure) IT-1.20 Other: % patients who by age 13 were up-to-date with recommended adolescent immunizations: MCVS, Tdap	$23,643,981
127295703.2.2 Project Withdrawn Parkland Health & Hospital System 127295703	Project Withdrawn	Project Withdrawn	$0
127295703.2.3 Project Withdrawn Parkland Health & Hospital System 127295703	Project Withdrawn	Project Withdrawn	$0
127295703.2.4 Expand chronic care model Parkland Health & Hospital System 127295703	2.2.1 - Implement a chronic care model that reflects the evidence-based Wagner Chronic Care Model in COPC primary care clinics	IT-1.2 Annual monitoring of patient on persistent meds - ACE inhibitors/ ARBS (Non-standalone Measure) IT-1.12 Diabetes: Retinal Eye Exam (NQF 0055) (Non-standalone Measure) IT-3.3 Diabetes 30-Day Readmission Rate (Stand-alone Measure)	$31,167,066
127295703.2.5 Assess cost effectiveness of post-acute care alternatives Parkland Health & Hospital System 127295703	2.5.2 - Produce methodology using well developed cost-effectiveness data to evaluate expansions, contractions or changes of the care continuum with objective of providing integrated, patient-centered, cost effective care	IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (Stand-alone) IT-5.2 Per episode cost of care (Stand-alone Meaure)	$29,375,855

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**
127295703.2.6 Apply Process Improvement Methodology - PPCs Parkland Health & Hospital System 127295703	2.8.5 - Implement interventions to reduce potentially preventable complications (PPCs)	IT-4.2 CLABSI Rates (Stand-alone Measure) IT-4.3 CAUTI Rates (Stand-alone Measure) IT-4.4 SSI Rate (Stand-alone Measure) IT-4.8 Sepsis Mortality	$31,167,066
127295703.2.7 Enhance patient care navigation program Parkland Health & Hospital System 127295703	2.9.1 - Implement strategic redesign of Parkland's case coordination program including patient navigation program	IT-3.1 All Cause 30-Day Readmissions Rate – NQF 178935 (Stand-alone Measure)	$22,211,012
127295703.2.8 Implement palliative care program Parkland Health & Hospital System 127295703	2.10.1 - Execute a planning process to implement a palliative care program	IT-13.3 Proportion of patients with more than one ED visit in the last days of life (NQF 0211) – Percentage of patients who died from cancer with more than one emergency room visit in the last days of life (Stand-alone Measure)	$25,972,554
127295703.2.9 Implement care transitions program Parkland Health & Hospital System 127295703	2.12.1 - Redesign Parkland's care coordination program including highly functional care transitions / discharge process	IT-3.1 All Cause 30-Day Readmissions Rate – NQF 178935 (Stand-alone Measure)	$24,539,587

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**
127295703.2.10 Increase Patient Satisfaction Parkland Health & Hospital System 127295703	2.4.3 – Increase patient satisfaction across through system-wide focus and efforts	IT-6.1 Percent improvement over baseline of patient satisfaction scores	$19,703,317
127295703.2.11 – Pass 2 Enhance/Expand Medical Home Model – Family Medicine Clinic Parkland Health & Hospital System 127295703	2.1.1 – Enhance/Expand Medical Home Model – Family Medicine Clinic	IT-1.1 Third next available appointment IT-1.12 Diabetes: Retinal Eye Exam IT-1.13 Diabetes: Foot Exam	$15,225,291
127295703.2.12 – Pass 2 Apply Process Improvement Methodology to Improve Quality/ Efficency – OPAT Program Parkland Health & Hospital System 127295703	2.8.4 – Apply Process Improvement Methodology to Improve Quality/ Efficency – Outpatient Parenteral Antimicrobial Therapy (OPAT) Program	IT-3.12 Other: All Cause 30-day Readmission Rate for Patients Enrolled in OPAT program	$25,972,554
020908201.2.1 Project Withdrawn Texas Health Presbyterian Hospital Dallas 020908201	Project Withdrawn	Project Withdrawn	$0
020908201.2.2 Implement Evidence-based Health Promotion Programs Texas Health Presbyterian Hospital Dallas 020908201	2.6.2 - Faith Community Health/Nursing program will partner with faith communities to design self-management wellness program.	IT-1.7 Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Stand-alone Measure) IT-1.11 Diabetes: BP Control (< 140/ 90mm hg) (NQF 0061) (Stand-alone Measure)	$2,389,097

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**
020908201.2.3 – Pass 2 Enhance Medical Home Model: Healing Hands Ministries Texas Health Presbyterian Hospital Dallas 020908201	2.1.2 – Collaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients	IT-11.5 All Cause Readmission Rate for Chronically Ill IT-5.1 Improved cost savings: demonstate cost savings in care delivery	$10,556,611
020967801.2.1 Expand patient care navigation program Texas Health Presbyterian Hospital Denton 020967801	2.9.1 - Implement ED-based nurse navigator program to assist with care coordination and avoid unnecessary ED visits or hospitalizations	IT-9.2 ED Appropriate Utilization (Stand-alone measure)	$2,796,366
020967801.2.2 Expand Chronic Care Management Models Texas Health Presbyterian Hospital Denton 020967801	2.2.1 - Develop diabetes management education program. A multi-disciplinary care team will coordinate treatment and provide self-management education and support	IT-1.10 Diabetes: HbA1c poor control (>9.0%) (NQF 0059) (Stand-alone Measure)	$521,347
094140302.2.1 Expand patient care navigation program Texas Health Presbyterian Hospital Kaufman 094140302	2.9.1 - Implement ED-based nurse navigator program to assist with care coordination and avoid unnecessary ED visits or hospitalizations	IT-9.2 ED Appropriate Utilization (Stand-alone measure)	$2,242,406
094140302.2.2 Expand Chronic Care Management Models Texas Health Presbyterian Hospital Kaufman 094140302	2.2.1 - Develop program with multi-disciplinary care team that will develop care models, coordinate prescribed treatment, and provide self-management education to diabetic patients	IT-1.10 Diabetes: HbA1c poor control (>9.0%) (NQF 0059) (Stand-alone Measure) IT-3.3 Diabetes 30-Day Readmission Rate (Stand-alone Measure)	$150,570

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**
126686802.2.1 Expand Medical Homes UT Southwestern Medical Center – Faculty Practice Plan 126686802	2.1.1 - Expand the medical home model of care in the UTSCAP primary care network	IT-12.1 Breast Cancer Screening (Non-standalone Measure) IT-12.3 Colorectal Cancer Screening (NSA) IT-12.4 Pneumonia vaccination status of older adults (NSA)	$12,791,024
126686802.2.2 Expand an Existing, Successful Advanced Training Program in Quality Improvement Methodology UT Southwestern Medical Center – Faculty Practice Plan 126686802	2.8.1 – Applying process improvement methodology to improve quality and efficiency by training in the methodology of quality improvement	IT-1.10 Diabetes care: HbA1c poor control (>9.0%) (NQF 0059) (Stand-alone measure) IT-3.1 All Cause 30-Day Readmission Rate (Stand-alone Measure)	$7,057,117
126686802.2.3 Redesign for Cost Containment UT Southwestern Medical Center – Faculty Practice Plan 126686802	2.5.1 – Develop integrated care model with outcome-based payments	IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery	$7,454,080
126686802.2.4 Establish/Expand a Patient Care Navigation Program UT Southwestern Medical Center – Faculty Practice Plan 126686802	2.9.1 - Establish a patient care navigation program at the University hospitals	IT-1.10 Diabetes: HbA1c poor control (>9.0%) (NQF 0059) (Stand-alone Measure) IT-3.1 All Cause 30-Day Readmission Rate (Stand-alone Measure)	$14,114,233
126686802.2.5 Implement/Expand Care Transitions Programs UT Southwestern Medical	2.12.1 - Implement a care transitions program at the University hospitals	IT-1.10 Diabetes: HbA1c poor control (>9.0%) (NQF 0059) (Stand-alone Measure) IT-3.1 All Cause 30-Day Readmission	$17,201,722

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**
Center – Faculty Practice Plan 126686802		Rate (Stand-alone Measure)	
126686802.2.6 – Pass 2 Conduct Medication Management Program UT Southwestern Medical Center – Faculty Practice Plan 126686802	2.11.2 - Implement enhanced patient medication management program to improve health outcomes	IT-3.12 Other - readmission rate - complications of medications readmissions	$6,589,027
175287501.2.1 – Pass 2 Enhance Patient Navigation Program – ED UT Southwestern Medical Center - St. Paul University Hospital 175287501	2.9.1 - Implement ED patient navigation system	IT 2.12 - Prevention Quality Indicators (PQI) Composite Measure Potentially Preventable Hospitalizations for Ambulatory Sensitive Conditions	$4,807,050
175287501.2.2 – Pass 2 Palliative Care Program UT Southwestern Medical Center - St. Paul University Hospital 175287501	2.10.1 - Expand Palliative Care Program	IT-13.1 Pain assessment (Non-standalone Measure) IT-13.2 Treatment preferences (Non-standalone Measure) IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in clinical record of discussion of spiritual/religious concerns or documentation	$7,316,378

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**
175287501.2.3 – Pass 2 Expand Transitional Care Program for Cancer Paients UT Southwestern Medical Center - St. Paul University Hospital 175287501	2.12.2 - Expand transitional care program for cancer patients – expand to surgical oncology, thoracic surgery, neurosurgery, breast surgery patients	IT-3.12 All Cause Readmission Rate for Cancer Patients	$6,939,803

Section III. Community Needs Assessment

Section III. Community Needs Assessment

To develop the Community Needs Assessment, a regional Task Force was convened by representatives from the following organizations: Baylor Health Care System, Children's Medical Center, Dallas County Medical Society, Dallas County Behavioral Health Leadership Team, HCA North Texas, Methodist Health System, North Texas Behavioral Health Authority, Parkland Health & Hospital System, Scottish Rite Hospital for Children, Texas Health Resources, UT Southwestern Medical Center, and ValueOptions of Texas.

This Task Force reviewed and identified the regional needs through data analysis, expert presentations, and committee discussions. The major criteria used to identify and rank regional priorities included population impact, alignment with intervention categories, and whether solutions lend to regional based approaches. The following priorities were identified as the region's major community health needs:

Capacity - Primary and Specialty Care - The demand for primary and specialty care services exceeds that of available medical physicians in these areas, thus limiting healthcare access.

Behavioral Health - Adult, Pediatric and Jail Populations - Behavioral health, either as a primary or secondary condition, accounts for substantial volume and costs for existing healthcare providers, and is often utilized at capacity, despite a substantial unmet need in the population.

Chronic Disease - Adult and Pediatric - Many individuals in North Texas suffer from chronic diseases that present earlier in life, are becoming more prevalent, and exhibit complications.

Patient Safety and Hospital Acquired Conditions – Hospitals in the region address patient safety and care quality on a daily basis. It is a continuous improvement initiative and is always at the forefront of any strategy for a health care entity. An ongoing coordinated effort among providers is needed to improve patient safety and quality throughout the region.

Emergency Department Usage and Readmissions - Emergency departments are treating high volumes of patients with preventable conditions, or conditions that are suitable to be addressed in a primary care setting. Additionally, readmissions are higher than desired, particularly for those with severe chronic disease or behavioral health.

Palliative Care - Overall, costs are high in skilled nursing facilities, long term care facilities, hospice and home health sectors, and slightly higher in physician services.

Oral Health - In Texas, preventive dental visits are below the recommended levels, and access can be a problem for minorities, the elderly, children on Medicaid, and other low income children. Compounding the issue is the shortage of dentists in Texas at approximately 60% of the national ratio of dentists to the population.

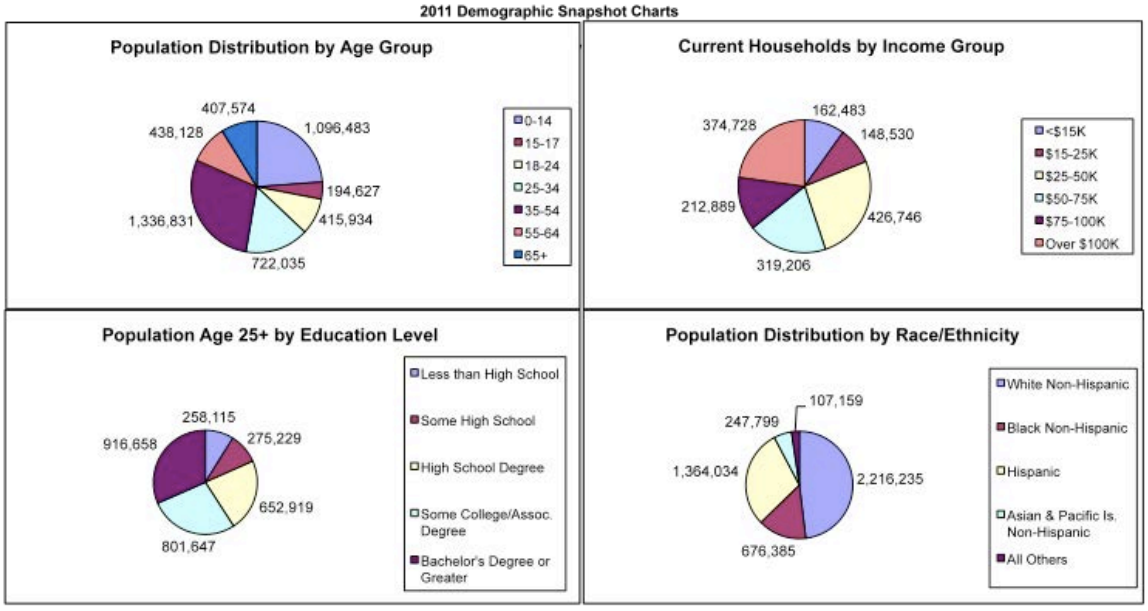
Demographics and Regional Description

Based on population alone, Texas is the second largest state in the nation with more than 25 million people. From 2000 to 2010, Texas experienced a 20% growth in population, as compared to only a 9.7% increase nationally. Originally, the North Texas RHP 9 Region was defined to include Collin, Dallas, Denton, Ellis, Fannin, Grayson, Kaufman, Navarro, and Rockwall counties. The broader demographics were considered to be representative of the narrower final RHP boundaries and as demonstrated in Figure 3 below, there is considerable in-migration from the original RHP counties to Dallas County for health care services.

In the North Texas RHP 9 region (original definition), the 2011 population is estimated to be 4,611,612 and is expected to grow by 9.5% by 2016 to 5,048,283 residents.[3] The most prevalent age group is 35-54 years (27.6%), followed by the 0-14 age group (20.2%). While 15.1% of adults have less than some high school level of education, approximately 85% of adults have at least a high school degree.

White non-Hispanics represent 48.1% of the population, followed by Hispanics, Black non-Hispanics, Asians, and others, respectively.[4] Approximately 44% of Dallas-Fort Worth residents are New Americans (defined as either foreign born or the children of foreign born) of which 46% are undocumented. English is not the language spoken in 32% of homes in North Texas and over 239 languages are spoken in the North Texas Area, with more than 1/3 reflecting African cultures new to the region.[5]

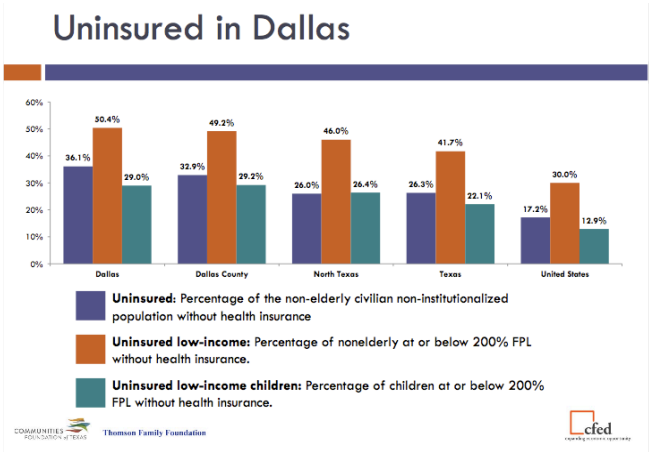
Figure 1: Regional Demographic Snapshot



[3] US Census Data, Thompson Reuters/Claritas Market Expert Data Extract, 2012.
[4] ibid.
[5] DFW International Community Alliance. 2010 North Texas Progress Report.

Within Dallas County specifically, 29.6% of children under 18 live below the federal poverty level and 15.8% of adults between 18 to 64 years live below the federal poverty level.[6]

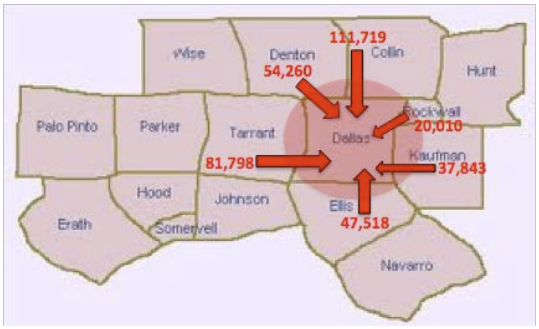
Figure 2: Summary of Uninsured in Dallas County[7]



Health Delivery System and Patient Migration Patterns

Data analysis identified patient migration patterns within multiple RHP regions. Many individuals receive healthcare services in nearby counties. In the pediatric population, Dallas County residents account for 75% of the outpatient services and 74% of the inpatient services. In the adult population, Dallas County residents account for 77% and 73% of the outpatient and inpatient population, respectively.[8]

Figure 3: Interconnectedness of Healthcare Delivery System: Dallas County Encounters from Patients with Adjacent County of Residence, 2011[9]



The locations of charitable clinics in Dallas County are shown on the map below. Additional analysis is warranted to determine the causal factors of the patient flow and migration patterns and how they relate to the locations of clinics/other service sites in the region. It is apparent though that the data presents strong justification to consider a broader geographic area for the purposes of this assessment.

[6] US Census Data. www.census.gov, 2011.
[7] Communities Foundation of Texas, Assets and Opportunities Profile. February 2012.
[8] DFWHC Foundation, Information and Quality Services Data Warehouse, 2011
[9] ibid.

Figure 4: Location of Charitable Clinics in North Texas[10]

Regional Health Care Capacity

Physician Supply and Availability

RHP 9 is affected by the limited physician capacity in primary and select specialties. According to the Health Professions Resource Center, primary care physician supply trends have consistently increased to a current statewide rate of 70 per 100,000 people in 2011.[11] In 2011, the RHP 9 region demonstrated a physician need in excess of over 30% of the current workforce and by 2016 the physician need is expected to be 50% higher than projected availability.[12] With such a shortage of physicians, which is disparately worse in rural areas of Texas, many residents seek primary care and non-emergent treatment in emergency departments, resulting in increased healthcare costs and higher volumes of preventable and avoidable cases in the ED.

Medical Education

Dallas County is home to the University of Texas Southwestern Medical Center, an academic medical center that trains over 1000 medical students and approximately 1300 clinical residents annually. Many training and residency placements are completed within the DFW Metroplex providing an important source of physicians to the local healthcare system.

Medically Underserved and Shortage Areas

A Health Professional Shortage Area (HPSA) is a federally designated geographic area, a facility or population group with a shortage of primary care physicians (or dental or mental health providers) as defined by a population-to-primary care physician ratio of at least 3,500:1 in

[10] Parkland Health & Hospital System. Charitable Clinic Locations Report. 2012.
[11] Health Professions Resource Center, Center for Health Statistics, Department of State Health Services, October 2011.
[12] ibid.

addition to other requirements designated by the U.S. Department of Health and Human Services.[13] Poverty rate, infant mortality rate, fertility rate and physical distance from care are all considerations in scoring for HPSA designation.

Medically Underserved Areas or Populations (MUA/MUP) are generally defined by the federal government to include areas of populations with a shortage of personal health care services or groups of people who may have cultural or linguistic barriers to health care. In RHP 9, Dallas County has significant HPSA and MUA regions that overlap and Kaufman County is a county-level HPSA with no MUAs.

Children/Youth

The impact of the limited primary and specialty care is profound for children and families in the region. The current pediatric need is more than 80% of the current supply in the region. In Dallas County alone, over 36.2% of children were enrolled in Medicaid in 2010, exacerbating the issue of availability of pediatric primary care access and treatment.[14] Data also indicates that many of the pediatric specialists have limited capacity, creating a backlogged pipeline for those needing specialty services after seeking primary care.

Behavioral Health

Behavioral Health System Structure and Funding

The behavioral health system (including mental health and substance use) in RHP 9 differs from that of the rest of the state in that the majority of behavioral services for Medicaid and indigent patients are delivered through the NorthSTAR program instead of the traditional Local Mental Health Authority (LMHA) system. It is a managed behavioral healthcare carve-out program, administered by ValueOptions of Texas under a Medicaid 1915(b) waiver under the oversight of the North Texas Behavioral Health Authority (NTBHA), and it provides both mental health and substance use treatment to over 60,000 Medicaid enrollees and indigent uninsured annually.

Over the past decade, the NorthSTAR program has greatly expanded access to care. However, this high level of access results in funding and infrastructure challenges. Since the program's inception, the growth in enrollment has outpaced funding such that the funding per person served is 30% less than when the program started in 1999 and is half that of the state average for other LMHAs[15]. Given that Texas is 50th in mental health funding nationwide[16], the funding per person served in RHP 9 is among the lowest in the nation.

Mortality Trends in the Behavioral Health Population

An inadequate supply of behavioral health services is one of the most significant unmet health needs of RHP 9. A recent study in Texas found that NorthSTAR was one of only four LMHAs in which age-adjusted mortality rates were significantly higher for the mental health population compared to the general population. Consistent with the NASMHPD study, the majority of

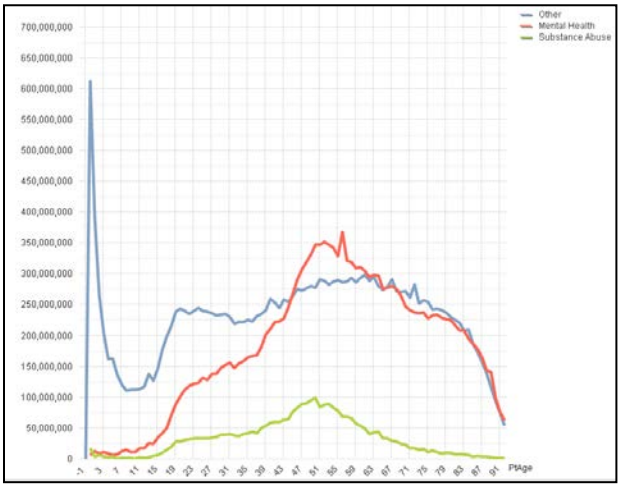
[13] US Department of Health and Human Services. 2012.
[14] Children's Medical Center. Beyond ABC Report, 2011.
[15] TriWest/Zia Partners. Assessment of the Community Behavioral Health Delivery System in Dallas County, 2010.
[16] National Alliance on Mental Illness. State Mental Health Cuts: The Continuing Crisis. March 2011.

deaths in this region were due to medical illness, and most of those were due cardiovascular disease.[17] The NorthSTAR system differs from the rest of the state in that it includes patients with primary diagnoses of substance use disorders, a preliminary analysis of death records showed similar mortality rates between the mental health and substance abuse populations.[18]

Cost Trends in the Behavioral Health Population

The financial implications of caring for those with behavioral health conditions are substantial and impact resources within the healthcare institutions of RHP 9. Analysis of DFW Hospital Council Foundation data demonstrates that charges associated with the care of mental health patients more than doubles from $50,000,000 to over $100,000,000 between the ages of 17 through 21. Charges continue to rise through adulthood, and between the ages of 47-65, the estimated charges for mental health encounters are higher than those of all other conditions combined. When substance abuse encounters are included, this difference is even greater.[19]

Figure 5: Age and Charge Distribution by Mental Health and Substance Abuse Encounter (2010Q3-2011Q3)[20]



In RHP 9, the presence of a co-occurring behavioral health condition is associated with increased case severity of medical encounters and a 36% increase in the average charges per encounter. In RHP 9, 100% of the 10 most frequently admitted patients had a co-occurring behavioral health diagnosis depicted in Figure 5. These 10 individuals incurred a cost of more than $26 million between 2007 and 2011; however only 1/5 of their hospital emergency department visits were for a mental health or substance abuse issue. Sixty-one percent were uninsured (24% Medicaid, 12% Medicare, and 3% Insured).

[17] Mortality of Public Mental Health clients treated at the Local Mental Health Authorities of Texas, 2012.
[18] Personal communication between EA Becker and M Balfour
[19] Dallas Fort Worth Hospital Council Foundation, Readmission Patterns by Mental Health & Substance Abuse, 2012
[20] DFWHC Foundation, Information and Quality Services Data Warehouse, 2012.

Figure 6: Mental Health and Substance Abuse: Intersection

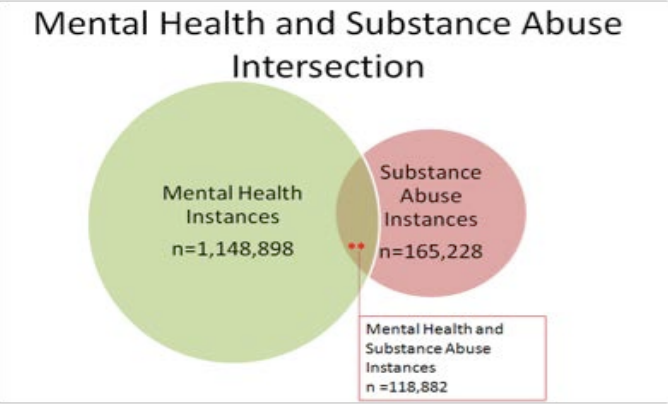


Figure 7: Top Ten High Emergency Department Utilizers: Mental Health and Substance Abuse Integration - Behavioral Health and Primary Care

DFWHC Foundation, Information and Quality Services (IQSC) Data Warehouse

Mental Health and Substance Abuse Interactions with Readmissions Patterns: Most Frequent 10 Patients (In and Outpatient)

RHP9 Cohort: 2007Q1 - 2011Q3

QUID	Total Cases	Mental Health	Substance Abuse	2007	2008	2009	2010	2011	Hospitals Visited	Average LOS (Days)	Uninsured	Insured	Medicaid	Medicare	Total Charges	Average Total Charges
430172	571	356	111	98	137	109	138	89	6	1.7375	2%	6%	86%	5%	$1,326,311.	$2,323.
811367	537	396	17	110	117	109	125	76	22	1.0152	0%	0%	0%	100%	$931,952.	$1,735.
1495682	490	267	35	77	125	125	83	80	26	1.3313	6%	15%	79%	0%	$2,310,619.	$4,716.
3554434	397	266	34	45	39	115	121	77	4	3.2897	99%	1%	0%	0%	$577,739.	$1,455.
3358467	379	297	10	15	38	56	116	154	7	1.4190	4%	39%	0%	57%	$369,397.	$975.
3048466	370	297	14	62	143	82	52	31	23	1.9093	11%	4%	24%	61%	$2,145,038.	$5,797.
1590501	362	245	94	60	2	118	101	81	4	10.5363	14%	1%	3%	82%	$289,747.	$800.
1993887	362	201	7	63	68	124	66	41	24	0.9448	7%	8%	84%	1%	$1,805,928.	$4,989.
1308998	361	235	133	37	51	93	122	58	9	1.2975	48%	2%	50%	0%	$1,804,562.	$4,999.
1411963	334	312	1	71	106	26	10	121	19	1.5736	45%	5%	50%	0%	$637,233.	$1,908.

The percentage of residents below 200% Federal Poverty Level in Dallas County who receive behavioral healthcare in primary care settings is 19.8% which is significantly lower than the national average of 37.1%.[21] Parkland, the largest primary care provider to low-income populations in Dallas County, is not a NorthSTAR provider and consequently, some who may be successfully served in primary care settings are referred to NorthSTAR. This may result in dilution of limited NorthSTAR resources, as well as coordination of care issues for those with high complexity co-occurring illness. An analysis of the diabetic population at Parkland revealed that diabetics receiving antipsychotic medications from the NorthSTAR system were twice as likely to receive second-generation antipsychotics, which adversely affect metabolic indicators associated with poor diabetes outcomes, compared to those receiving antipsychotics from the Parkland pharmacy.[22]

[21] TriWest/Zia Partners. Assessment of the Community Behavioral Health Delivery System in Dallas County, 2010.
[22] Balfour, ME et al. Highlighting High Utilizers: How can our systems better meet their needs? Institute on Psychiatric Services Annual Meeting, 2011.

The funding challenges combined with the complexity of the behavioral health system may adversely impact sub-populations with the highest needs. The number of NorthSTAR enrollees booked into jail has been steadily increasing as shown below in Figure 8[23], and 27% of all book-ins to the Dallas County Jail are currently referred to jail behavioral health services.[24] Homeless individuals with behavioral health conditions cost three times as much and are booked into jail twice as often as the general NorthSTAR population.[25] Among high utilizers, these relationships are magnified, as illustrated below.

Figure 8: Behavioral Health Patient Factors for Top 20% Utilizers of NorthSTAR, Dallas County Jail, and Terrell State Hospital, 2010

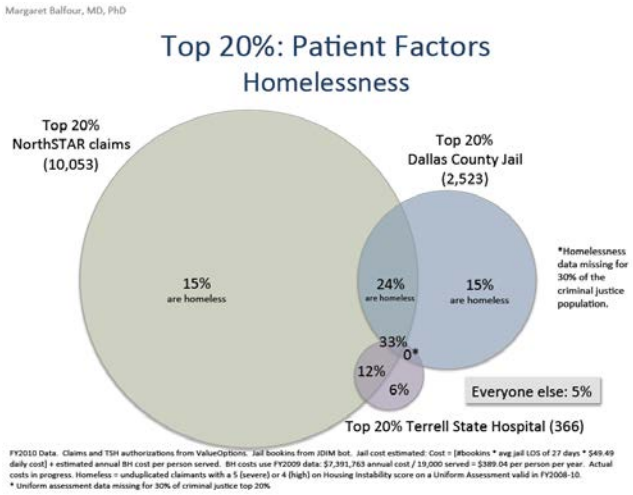
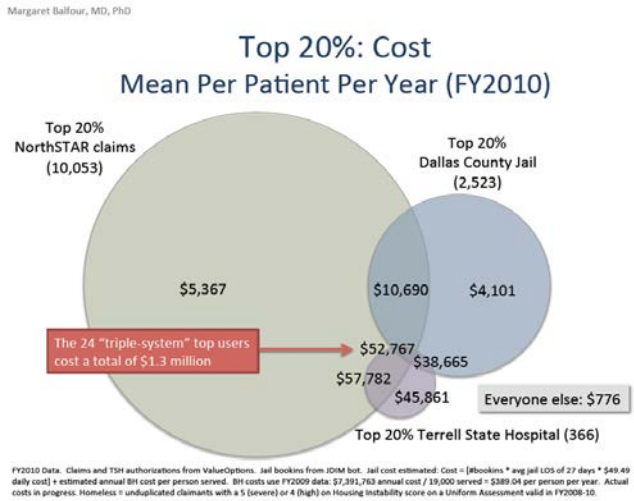


Figure 9: Behavioral Health Costs for Top 20% Utilizers of NorthSTAR, Dallas County Jail, and Terrell State Hospital, 2010



[23] Ron Stretcher and Jill Reese, Dallas County Criminal Justice Department
[24] Communication between Wassem Ahmed, Medical Director-Parkland Jail Behavioral Health and M. Balfour, MD
[25] Balfour, ME. Homelessness, Criminal Justice, and the NorthSTAR Top 200 Report, 2011.

Children/Youth

The number of Dallas County children receiving publicly funded mental health services has tripled from 2000 to 2010. In Dallas County, the number of children identified with a diagnosable emotional disturbance or addictive disorder has increased to approximately 142,000 children with 5% of those children experiencing a significant impairment as a result. Among youth between the ages of 12-17, 7.2% have experienced a major depressive episode.

Cultural and Linguistic Minorities

Hispanics comprise 40% of the population but only 25% of the NorthSTAR population.[26] While there is a lack of services available and written materials available in Spanish, it is difficult to characterize the extent of the need, because data on primary language is not collected.

Demand for Behavioral Health Services

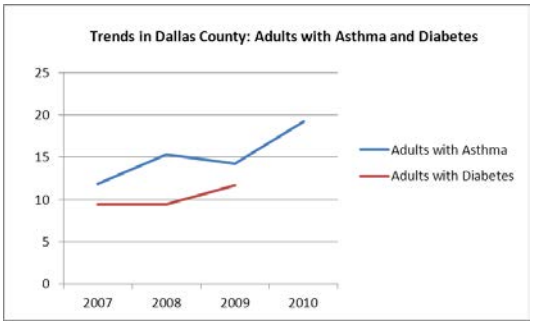
Following the economic downturn in 2009, there was a 17% increase in 23-hour observation visits at Green Oaks Hospital, mostly accounted for by new enrollees to NorthSTAR. More recently, there has been a sharp spike in 23-hour observation utilization, with Feb 2012 visits 26% higher compared to Dec 2011 (and 25% higher compared to Feb 2011).[27] This increase coincided with both regulatory oversight limiting the capacity of Parkland's Psychiatric ED by 50% and a reduction in funding for outpatient services in the NorthSTAR system.

In addition to hospital-type services, there is also a need for less-acute levels of behavioral care in order to prevent the need for these high-cost services. A sub-acute crisis residential level of care exists but there are only 21 beds for the entire NorthSTAR region. The Behavioral Health Leadership Team has identified the highest need for service development to be post-crisis "wraparound" services to reduce the 20% 30-day readmission rate to crisis services, and peer-driven services to engage clients early in order to prevent crisis episodes.

Chronic Disease

Similar to national trends, North Texas is experiencing increasing rates of many chronic diseases, including heart disease, cancer and stroke. Also there are increasing rates of asthma and diabetes in adults within the Dallas County Metropolitan Statistical Area as shown below.

Figure 10: Dallas County Adults with Asthma and Diabetes



In an assessment of ED utilization, the five encounter types that were most frequent and of highest volume are those for chronic conditions of asthma, chronic bronchitis, pain/aching of

[26] TriWest/Zia Partners. Assessment of the Community Behavioral Health Delivery System in Dallas County, 2010.
[27] ValueOptions of Texas

joints, sinusitis, and hay fever.[28] There were slight variations presented when encounters were analyzed by payer type. More Medicaid and uninsured patients sought treatment for asthma than those with insurance or Medicare and for the uninsured specifically, diabetes was listed as the 5th top condition, while not even listed as a top 5 condition for the insured or Medicaid.

Figure 11: Volume for Adult Outpatient Emergency Department Encounters (2010Q3 - 2011Q3)[29]

Highest Volume	1	2	3	4	5
All	Low Back Pain	Hypertension	Pain/Aching of Joints	Chronic Bronchitis	Asthma
Insured	Low Back Pain	Hypertension	Pain/Aching of Joints	Chronic Bronchitis	Asthma
Medicaid	Low Back Pain	Pain/Aching of Joints	Asthma	Chronic Bronchitis	Depression/ Anxiety
Medicare	Low Back Pain	Hypertension	Chronic Bronchitis	Pain/Aching of Joints	Diabetes
Uninsured	Low Back Pain	Pain/Aching of Joints	Hypertension	Asthma	Diabetes

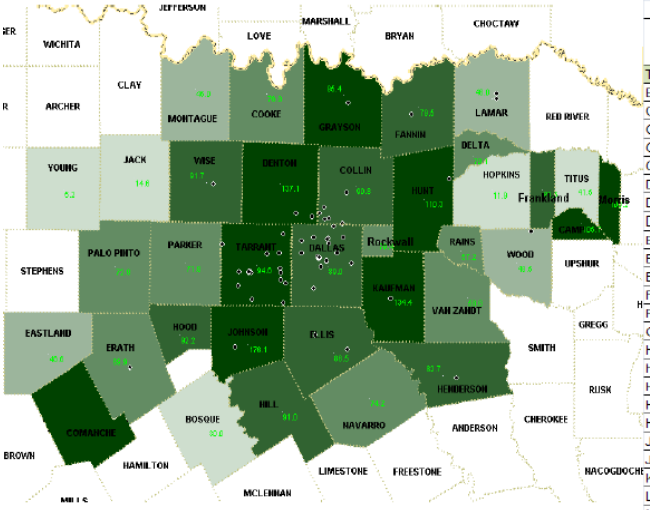
Asthma

Over the past decade, asthma has become a widespread public health problem that has increased in both Texas and the United States. Asthma has a major impact on the health of the population and the burden falls unevenly on some populations. According to Texas Behavioral Risk Factor Surveillance System in 2005, approximately 1.5 million adults (ages 18 and older) and 389,000 children (ages 0-17) were reported to have asthma at the time.[30] And in 2006, the state of Texas spent over $391.5 million for inpatient admissions with a primary discharge diagnosis of asthma.[31]

In 2008, the state of Texas had a risk-adjusted admission rate of 72.5 per 100,000 cases.[32] Although Dallas County had a slightly higher rate at 89.1 per 100,000 cases, six of the ten counties surrounding Dallas County were significantly more burdened with a risk-adjusted admission rate of greater than 92.2 per 100,000 cases. Only one county of the ten had a lower risk-adjusted rate (Rockwall County) at 70.5 per 100,000 cases. Other North Texas counties' astham admission rates are shown in the table below.

[28] Dallas Fort Worth Hospital Council Foundation, Information and Quality Services Data Warehouse. March 2011.
[29] Dallas Fort Worth Hospital Council Foundation, Information and Quality Services Data Warehouse. March 2011.
[30] Asthma Coalition of Texas. Texas Asthma Plan. 2007-2010.
[31] Asthma Coalition of Texas. 2012.
[32] AHRQ Prevention Indicators. Adult Asthma Admission Rate. 2008

AHRQ Prevention Quality Indicators
Adult Asthma Admission Rate - 2008



Named counties without shading have a Risk Adjusted rate of zero.

Risk Adjusted Rates per 100,000 Population

- 1 to 41.5
- 41.5 to 48.5
- 48.5 to 76.0
- 76.0 to 92.2
- > 92.2
- DI Hospitals

15 Adult Asthma Admission Rate

Asthma is one of the most common reasons for hospital admission and emergency room care. Most cases of asthma can be managed with proper ongoing therapy on an outpatient basis. Most published studies combine admission rates for children and adults; therefore, areas may wish to examine this indicator together with pediatric asthma.

2008				Per 100,000 cases		
county	Observed	Numerator (Outcomes)	Denominator (Population)	Risk Adjusted Rate	Confidence Interval	Stat. Sig
Texas	84.7	15,718	18,560,901	72.5	(71, 73.9)	O
BOSQUE	41.2	6	14,580	30.1	(0, 77.2)	O
CAMP	191.8	18	9,386	105.8	(54.8, 156.8)	O
COLLIN	61.8	324	524,278	90.9	(79.7, 102)	-
COMANCHE	201.0	22	10,947	105.0	(59, 150.9)	O
COOKE	86.6	26	30,030	76.1	(40.1, 112.1)	O
DALLAS	103.2	1,785	1,729,044	89.1	(84.4, 93.8)	-
DELTA	89.4	4	4,472	70.1	(0, 158.2)	O
DENTON	94.4	416	440,803	137.2	(125.1, 149.3)	-
EASTLAND	88.0	13	14,759	46.7	(6.8, 86.6)	O
ELLIS	71.3	75	105,148	86.6	(64, 109.2)	O
ERATH	73.2	20	27,307	70.0	(30.6, 109.4)	O
FANNIN	88.8	24	27,025	79.5	(41.2, 117.9)	O
FRANKLIN	107.1	9	8,401	80.5	(17.6, 143.5)	O
GRAYSON	109.6	102	93,065	95.4	(75.1, 115.8)	-
HENDERSON	105.9	68	64,198	82.7	(59.5, 106)	O
HILL	114.0	32	28,081	91.1	(55.6, 126.6)	O
HOOD	92.3	37	40,058	92.3	(59, 125.5)	O
HOPKINS	15.3	4	26,199	12.0	(0, 48.4)	+
HUNT	134.9	88	65,251	110.4	(86.8, 134)	-
JACK	13.3	1	7,517	14.6	(0, 95.1)	O
JOHNSON	156.6	179	114,276	176.1	(155.2, 197)	-
KAUFMAN	118.1	84	71,115	134.4	(107.8, 161)	-
LAMAR	85.1	33	38,769	46.1	(21.2, 70.9)	+
MONTAGUE	62.9	10	15,908	46.1	(0.9, 91.3)	O
MORRIS	144.3	15	10,398	109.3	(52.5, 166)	O
NAVARRO	89.4	34	38,032	74.2	(43.1, 105.3)	O
PALO PINTO	92.1	20	21,712	72.8	(32.7, 113)	O
PARKER	64.4	54	83,886	71.8	(47.5, 96.1)	O
RAINS	73.6	7	9,507	57.3	(0, 117.5)	O
ROCKWALL	51.1	27	52,789	70.5	(36.5, 104.5)	O
TARRANT	83.7	1,042	1,244,658	94.7	(88.3, 101)	-
TITUS	50.5	11	21,764	41.6	(0.7, 82.5)	O
VAN ZANDT	68.9	29	42,097	58.6	(28.7, 88.5)	O
WISE	77.6	35	45,104	91.8	(57.7, 125.9)	O
WOOD	63.6	22	34,584	48.5	(17.3, 79.8)	O
YOUNG	7.0	1	14,276	5.3	(0, 53.6)	O

Texas Hospital Inpatient Discharge Public Use Date File, FY2006. Texas Health Care Information Council, Austin, Texas. January, 2008.

+ = County's RA rate significantly lower than State RA rate

- = County's RA rate significantly higher

O = No statistical difference

<u>Diabetes</u>

Diabetes affects 11.4% of the population in Dallas County, which is above both the state average of 10% and the national average of 8%. In patients seen throughout the regional healthcare system and who are residents of Dallas County, the top five primary diagnoses, those patients with an underlying condition of diabetes were 29% for pneumonia, 39% for septicemia, 31% for other rehabilitation, 34% of urinary tract infection and 45% of acute kidney failure.[33] Those with diabetes had a higher mortality percentage than those without in four of the five top inpatient diagnoses revealing that a co-morbidity of diabetes increases your risk for mortality.

Dallas County's top seven diagnoses for ER patients were Acute URI Unspecified, Otitis Media, abdominal pain, chest pain unspecified, urinary tract infection, headache and other chest pain. Within those top seven diagnoses, 20%-45% had an underlying condition of diabetes. Specifically, of all patients who came to the ER with chest pain as a diagnosis, 21%-25% had a comorbidity of diabetes. Of patients presenting with abdominal pain, urinary tract infections and headache, 10% also had diabetes.

[33] Doughty, P. et al. Diabetes in Dallas County: Provider Report. 2011

Figure 12: Prevalence of Co-Occurring Diabetes, Dallas County 2009-2010

Top Five Diagnosis **INPATIENTS 2009-2010 Dallas County**	Number of Patients	Number of Patients with Diabetes	% with Diabetes	Mortality %	Mortality % with Diabetes
Pneumonia	4,359	1,279	29%	3.1%	3.5%
Septicemia	3,142	1,217	39%	21.4%	23.0%
Other Rehabilitation	2,816	872	31%	0.1%	0.1%
Urinary Tract Infection	2,447	822	34%	0.5%	0.6%
Acute Kidney Failure Unspecified	2,355	1,068	45%	3.2%	3.5%
Top Seven Diagnosis **ER VISITS 2009-2010 Dallas**	Number of Patients	Number of Patients with Diabetes	% with Diabetes	Mortality %	Mortality % with Diabetes
Acute URI Unspecified	23,979	392	2%	0%	0%
Otitis Media	18,576	84	0%	0%	0%
Abdominal Pain	14,677	1,516	10%	0%	0%
Unspecified Chest Pain	14,511	3,010	21%	0%	0%
Urinary Tract Infection	14,302	1,254	9%	0%	0%
Headache	13,531	1,228	9%	0%	0%
Other Chest Pain	13,217	2,980	25%	0%	0%

Children/Youth. Between 2000 and 2010, the number of Children's Medical Center admissions of youth with a primary or secondary diagnosis of diabetes increased by 34%. With the association of diabetes and obesity, there is also cause for concern of the future trajectory as low income preschool obesity within the Dallas Metropolitan Statistical Area was 17.2% in 2009, placing many young children at higher rates of developing diabetes in later years.[34]

Cost/Charge. Isolation of a specific "direct cost" is complicated. However, it is understood that the societal burden for this condition is extremely large and has manifestations in healthcare service utilization due to increases complexity and severity of other co-occurring medical conditions. Additionally, there are important societal costs of lower economic productivity of individuals with severe diabetic complications. The magnitude of the issues is only projected to increase as more people begin to develop diabetes at earlier in life.

Patient Safety and Quality and Hospital Acquired Conditions

The DFWHC Foundation's 77 hospitals had 1,706 adverse hospital events in 2010. These events included air embolism, Legionnaires, Iatrogenic Pneumothorax, delirium, blood incompatibility, glycemic control issues and Clostridium difficile, which are not part of the ten adverse events specified by CMS. A significant portion was made up of Medicare patients (46%) and insured (54%) according to the claims data within the DFWHC Foundation claims data warehouse.

Emergency Department Usage and Readmissions

An analysis of the emergency department encounters demonstrates that many in the population are accessing emergency departments for both urgent and non-urgent conditions. Over the most recent four quarters of data, the conditions for which the most volume of care

[34] Children's Medical Center. Beyond ABC Report, 2010.

was provided in an emergency outpatient setting were: low back pain, hypertension, pain/joint aching, chronic bronchitis, and asthma.

Further assessment demonstrates that, with the exception of asthma, over 68% of the encounters for the top primary health conditions listed above were either non-emergent or emergent/primary care treatable, in that the care could have been provided effectively in a primary care setting. For asthma, approximately 98.1% of all encounters were emergent, however the condition could have been potentially avoidable or preventable if effective ambulatory care could have been received during the illness episode.[35]

For emergency department encounters that resulted in a hospital admission, the most common health conditions by volume include stroke, diabetes, congestive heart failure, weak/failing kidneys, chronic bronchitis and heart attack. When reviewing by payer type, diabetes is the top condition for the uninsured and Medicaid and the 5th top condition for those who are insured.

Figure 14: Adult Inpatient Emergency Department Encounters (2010Q3 - 2011Q3)[36]

Highest Volume	1	2	3	4	5
All	Stroke	Congestive Heart Failure	Weak/Failing Kidneys	Chronic Bronchitis	Diabetes
Insured	Stroke	Weak/Failing Kidneys	Congestive Heart Failure	Heart Attack	Diabetes
Medicaid	Diabetes	Congestive Heart Failure	Weak/Failing Kidneys	Stroke	Chronic Bronchitis
Medicare	Congestive Heart Failure	Stroke	Weak/Failing Kidneys	Chronic Bronchitis	Heart Attack
Uninsured	Diabetes	Stroke	Weak/Failing Kidneys	Congestive Heart Failure	Heart Attack

Specific to children, the high volume ED encounters includes asthma, diabetes, pain/aching joints, and arthritis most frequently. Regardless of payer type, asthma and diabetes are the top conditions for ER and inpatient admissions.

Figure 15: Pediatric Inpatient Emergency Department Encounters (2010Q3 - 2011Q3)[37]

Highest Volume	1	2	3	4	5
All	Asthma	Diabetes	Pain/Aching of Joints	Arthritis	Congestive Heart Failure/Liver Condition
Insured	Asthma	Diabetes	Pain/Aching of Joints	Arthritis	Liver Condition
Medicaid	Asthma	Diabetes	Arthritis	Congestive Heart Failure	Pain/Aching of Joints
Uninsured	Asthma	Diabetes	Pain/Aching of Joints	Arthritis	Liver Condition/Low Back Pain

[35] DFWHC Foundation, Information and Quality Services Data Warehouse, 2011.
[36] Ibid.
[37] Ibid.

In North Texas, all-cause readmissions as defined by a subsequent admission within 30 days from the incident encounter of any type has demonstrated a downward trend since 2008.[38] Many hospitals are working to continue improvement in this area, specifically for readmission related to congestive heart failure, acute myocardial infarction, and pneumonia.

As evidenced by an assessment of 10 individual high utilizers in the region, there is a strong relationship between readmissions and behavioral health. Each patient has some component of mental health or substance abuse history over the course of their encounter history.

Figure 16: Top Ten High Emergency Department Utilizers: Mental Health and Substance Abuse

DFWHC Foundation, Information and Quality Services (IQSC) Data Warehouse

Mental Health and Substance Abuse Interactions with Readmissions Patterns: Most Frequent 10 Patients (In and Outpatient)

RHP9 Cohort: 2007Q1 - 2011Q3

QUID	Total Cases	Mental Health	Substance Abuse	2007	2008	2009	2010	2011	Hospitals Visited	Average LOS (Days)	Uninsured	Insured	Medicaid	Medicare	Total Charges	Average Total Charges
430172	571	356	111	98	137	109	138	89	6	1.7375	2%	6%	86%	5%	$1,326,311.	$2,323.
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1495682	490	267	35	77	125	125	83	80	26	1.3313	6%	15%	79%	0%	$2,310,619.	$4,716.
3554434	397	266	34	45	39	115	121	77	4	3.2897	99%	1%	0%	0%	$577,739.	$1,455.
3358467	379	297	10	15	38	56	116	154	7	1.4190	4%	39%	0%	57%	$369,397.	$975.
3048466	370	297	14	62	143	82	52	31	23	1.9093	11%	4%	24%	61%	$2,145,038.	$5,797.
1590501	362	245	94	60	2	118	101	81	4	10.5363	14%	1%	3%	82%	$289,747.	$800.
1993887	362	201	7	63	68	124	66	41	24	0.9448	7%	8%	84%	1%	$1,805,928.	$4,989.
1308998	361	235	133	37	51	93	122	58	9	1.2975	48%	2%	50%	0%	$1,804,562.	$4,999.
1411963	334	312	1	71	106	26	10	121	19	1.5736	45%	5%	50%	0%	$637,233.	$1,908.

Cost/Charge

From quarter 3 of 2010 to quarter 3 of 2011, the estimated charges associated with all regional emergency outpatient encounters was $312,816,490 and for emergency inpatient encounters, the total charges increase to $2,076,778,420. For emergency inpatient encounters, there was little charge variation across insured, Medicaid, Medicare, and Uninsured payer types.

Palliative Care

Palliative care is an important factor in the care delivery system of RHP 9. Overall, Medicare reimbursements to providers in Dallas County are higher than average and higher than the 50th percentile in the country during a patient's last two years of life signifying a large volume of palliative care services being provided. Even within the health service area of RHP 9, there is variability of the percentage of deaths occurring within hospitals, ranging from 0.69 percent to 1.17 when compared to the national average.

Oral Health

Tooth decay (dental caries) is the most common chronic childhood disease. In 2003, the proportion of Texas children reported to have teeth in excellent or very good condition was lower than the national average and lower within all age, sex, and racial/ethnic subgroups.

[38] DFWHC Foundation, Information and Quality Services Database, 2010.

Figure 17: Oral Health – Condition of Teeth for Texas Children (2003)

	Condition of Teeth: Excellent or very good		Preventive Dental Care: ≥ 1 Visit within Past Year	
	US %	Texas %	US %	Texas %
Age Group				
All children 0–17	64.3	57.6	67.6	61.6
Age (years)				
1–5	75.8	70.7	46.8	48.4
6–11	61.7	50.9	83.4	74.8
12–17	67.4	61.2	79.4	69.7
Socioeconomic status				
0–99% Federal poverty level	45.4	40.7	54.1	56.0
100–199% Federal poverty level	56.5	48.9	61.6	52.6
200–399% Federal poverty level	71.2	66.7	73.0	67.4
≥400% Federal poverty level	78.1	78.3	77.8	73.3
Race/ethnicity				
White	69.3	65.4	70.6	64.4
Black	57.4	53.4	62.6	64.9

Dental problems in adults are equally problematic. According to the U.S. Surgeon[39] most adults in the U.S. show signs of periodontal or gingival diseases and severe periodontal disease affects 14 percent of adults (ages 45–54 years). However, a little less than two-thirds of adults report visiting a dentist within the past 12 months, and those with incomes at or above the poverty level are twice as likely to report a dental visit in the past 12 months as those below the poverty level. The American Dental Association cited the major reason for not accessing regular oral health care is the high cost of dental care. And the number of individuals who lack dental insurance is more than 2.5 times the number of those who lack medical insurance.

Effective health policies intended to expand access, improve quality, or contain costs must consider the supply, distribution, preparation, and utilization of the workforce. According to the National Health Service Corps, Texas needs 784 additional dentists to achieve the recommended ratio of one dentist for every 3,000 residents. The overall supply of dentists in Texas has been consistently below the national average of 59-60 dentists per 100,000 for many years.[40] In 2006, Texas had 36.0 dentists per 100,000 and it has been declining since.

Summary

Additional analysis and information is presented in Appendix B.

[39] National Institute of Health. National Institute of Dental and Craniofacial Research. "Oral Health in America: A Report of the Surgeon General. 2000.

[40] State Department of Health & Human Services, Center for Health Statistics Health Professions Resource Center. Publication No. 25-12581. E-Publication No. E25-12581. March 2007.

Summary of Community Needs

Identification Number	Brief Description of Community Needs Addressed in RHP Plan	Data Source for Identified Need
CN.1	Community Description – Demographics	US Census Data, DFW International Community Alliance Report, Communities Foundation of Texas Report
CN.2	Regional Healthcare Infrastructure and Patient Migration Patterns	DFWHC Foundation, Information Quality and Services Data Warehouse, Parkland Health and Hospital System
CN.3	Healthcare Capacity	Health Professions Resource Center, Center for Health Statistics, US Department of Health and Human Services; Children's Medical Center Beyond ABC Report; Horizons (2012): The Dallas County Community Health Needs Assessment
CN.4	Primary Care and Pediatrics	Health Professions Resource Center, Center for Health Statistics, US Department of Health and Human Services, Children's Medical Center Beyond ABC Report
CN.5	Behavioral Health	TriWest/Zia Partners Report, National Alliance on Mental Illness, DFWHC Foundation, Information Quality and Services Data Warehouse
CN.6	Behavioral Health and Primary Care	TriWest/Zia Partners Report, National Alliance on Mental Illness, DFWHC Foundation, Information Quality and Services Data Warehouse, Horizons: The Dallas County Community Health Needs Assessment
CN.7	Behavioral Health and Jail Population	Dallas County Criminal Justice Department, Parkland Health and Hospital System
CN.8	Specialty Care	DFWHC Foundation, Information and Quality Services Data Warehouse retrieved March 2012, Children's Medical Center Beyond ABC Report, 2011 US Census Data, Thompson Reuters/Claritas Market Expert Extract prepared by Devin Hill, Baylor Health Care System, generated February 2012.
CN.9	Chronic Disease	DFWHC Foundation Information Quality and Services Data Warehouse, Diabetes in Dallas County Report, Children's Medical Center Beyond ABC Report, Horizons: The Dallas County Community Health Needs Assessment
CN.10	Oral Health	US Department of Health and Human Services Healthy People 2010, Texas Department of State Health Services Oral Health Program, DSHS Primary Care Office
CN.11	Patient Safety and Quality	DFWHC Foundation Information Quality and Services Data Warehouse, Institute of Medicine Report
CN.12	Emergency Department Usage and Readmissions	DFWHC Foundation Information Quality and Services Data Warehouse
CN.13	Palliative Care	Barnato et al., Teno et al., Wennenberg et al.

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Section IV. Stakeholder Engagement

Section IV. Stakeholder Engagement

A. RHP Participants Engagement

In November 2011, as the prospects for approval of the proposed Section 1115 Medicaid waiver titled "Texas Healthcare Transformation and Quality Improvement Program" were becoming favorable, the Parkland Health & Hospital System (Parkland) administrative and board leadership requested Dallas Medical Resource assistance in the formation of a Dallas regional healthcare partnership and plan.

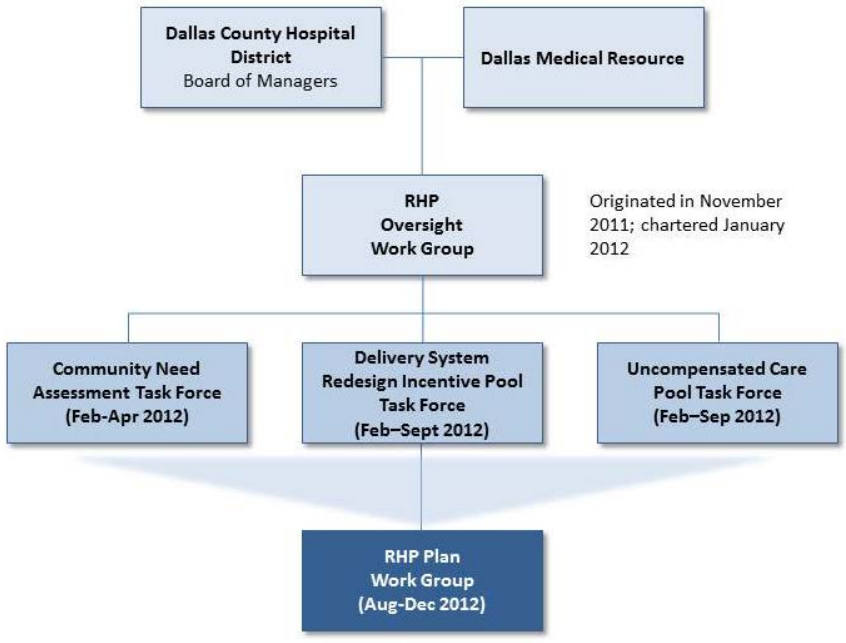
11.17.11 Letter from Parkland to DMR

"The development of the RHPs will be complicated and will require significant stakeholder involvement and community leadership. We believe that Dallas Medical Resource would be the perfect organization to help us initiate the discussions and assist us in the formation of a Dallas RHP and would formally request DMR's assistance."

Dallas Medical Resource (DMR) established in 1989 by the Greater Dallas Chamber of Commerce, is devoted to addressing major issues impacting the health of the Region's citizens and the health care delivery system. It is a partnership between the leaders of the business community and the medical and health care community. DMR serves as the forum for these groups to work together on such issues as supporting Parkland Health and Hospital System.

On November 22, 2011, DMR responded affirmatively to Parkland's request and proposed the organizational structure presented below for the RHP development. The structure was adopted and has been used throughout RHP 9's Plan development.

In partnership, DMR and Parkland have successfully engaged the participation of a broad array of stakeholders throughout the RHP 9's organizational journey.



The Work Group (steering committee representing Parkland, the performing providers, the business community and the medical society) and each of the task forces were led by Parkland and non-Parkland co-chairs. The Community Needs Task Force was co-chaired by

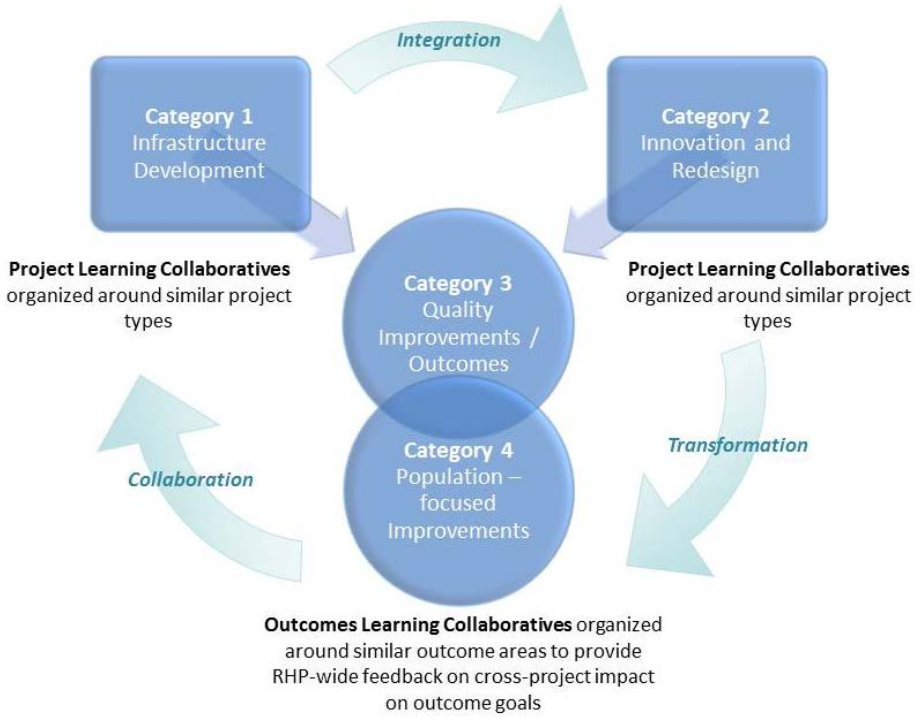
Steve Love, President and CEO of the Dallas-Fort Worth Hospital Council (DFWHC) and Jody Springer, Parkland. The DFWHC Foundation staff was commissioned to lead development of the Needs Assessment. The Delivery System Redesign Incentive Pool Task Force was co-chaired by Drs. Ron Anderson, Parkland, and David Ballard, Baylor Health Care System. The Uncompensated Care Pool Task Force was co-chaired by John Dragovits, Parkland, subsequently his successor, Ted Shaw, Parkland and Fred Savelsbergh, Baylor Health Care System. The RHP Plan Work Group was responsible for writing the RHP 9 plan using the work produced by the DSRIP and UC Task Forces. The RHP Plan Work Group was co-chaired by Jody Springer, Parkland and Fred Savelsbergh, Baylor Health Care System. The Task Forces and Work Groups were populated with representatives of the performing providers and other stakeholders constituting RHP 9. In addition to the appointed task force and work group members, meetings were open to attendance by additional representatives of the stakeholder organizations. There was consistent and regular meeting attendance by all stakeholders.

The oversight steering committee Work Group met monthly/bi-monthly receiving and acting on recommendations from the work group and task forces. The task forces generally met weekly throughout their respective terms. The work groups and task forces maintained meeting minutes. The RHP Plan Work Group from its establishment in August met frequently, often weekly. A meeting calendar and examples of meeting agendas / minutes have been included in Appendix D-1.

RHP 9 has enjoyed broad, diverse and actively engaged participants throughout this planning year as is reflected in Section I. In a view held among all of the RHP 9 participants, the engagement and collaboration generated throughout this planning year has already had substantial yield for the region in relationship building, coordination and cooperation among stakeholders. As the DSRIP projects are finalized and approved, RHP 9 will come together to develop an implementation structure that will govern the RHP throughout DY 2 through DY 5.

Project and Outcomes Learning Collaboratives

The figure that follows demonstrates the approach that RHP 9 will use to establish an innovative and productive learning and sharing environment. A twofold strategy is envisioned to approach the organization of learning collaboratives.



The *project* learning collaboratives will be structured around Category 1 and 2 projects so that best practices, methodologies and learning can be shared among the providers directly involved in similar interventions. In addition, *outcome* learning collaboratives will be organized around sets of aligned Category 3 and 4 outcome measures that cross multiple Category 1 and 2 projects. For example, an outcome learning collaborative might be established around chronic disease measures. There may be opportunities to create productive information sharing and feedback loops that will inform and improve the intervention effectiveness throughout the course of the RHP 9 plan. While the outcome learning collaboratives will focus primarily on the Category 3 measures, the population-focused Category 4 reporting indicators will also inform this work.

Each learning collaborative will maintain ongoing documentation of challenges encountered, solutions generated, lessons learned, process changes made, and results produced through the work of the collaborative.

RHP 9 will invest time and resources early in the implementation phase of the RHP 9 plan to assure the clinical, technical and development support is in place to establish a strong and appropriately organized and resourced learning collaborative model. The collegial relationships, communication, shared practices and technology (such as our Sharepoint site) established and utilized throughout the development of the RHP 9 Plan will be leveraged in the learning collaboratives.

Plan Conduct and Monitoring

RHP 9 will monitor the transformational impact that the plan has on the region. This will provide an opportunity for RHP 9, as a collective of independent organizations, to:

- Hold ourselves and one another accountable for progress toward goals,
- Learn together and help each organization to succeed,
- Recalibrate our interventions if they are not producing the desired impact,
- Continue to engage and enlarge the region stakeholders, and
- Reach out and assure bi-directional communication with the public.

In sum, RHP 9's participants are looking forward to embarking on the RHP 9 Plan's implementation.

B. Public Engagement

The formation of Region Nine took place over an extended period of time and was finalized in early August 2012. Throughout this formation period, there was considerable interaction with elected officials and other interested parties. It has been the intent and practice for RHP 9 to maintain full transparency. In May 2012 while the regional boundaries were still being determined, the completion of the Community Needs Assessment provided an opportunity to promote public awareness. The Needs Assessment was presented to the Parkland Board of Managers in May 2012 which resulted in an article in the Dallas Morning News.[41]

In August 2012, Parkland created a web site-let to provide information regarding Waiver, development of RHP 9 Plan and to provide an on-line opportunity for input. As of November 15, 2012, the website had 197 entrances and a total of 783 page views. From the time the web site went live, it has included a form to accept questions or comments.

It has been the policy and practice of RHP 9 to remain open to questions, comments and feedback throughout the Plan development process. Comment periods were not restricted and feedback has been and continues to be welcomed.

Pass 1 Public Meeting

On November 7, 2012, RHP 9 hosted its public meeting related to the submission of its Pass 1 plan. The meeting was held at 6:30 p.m. at the Dallas County Commissioners Court in Dallas. Parking fees were waived for meeting attendees.

On October 31, 2012, the informal notice for the public meeting and a web-ready notice were distributed to each participant in the RHP requesting that the notice be widely distributed and posted throughout the region. The notice provided the URL for the Parkland web site-let for the Medicaid 1115 Waiver.

The meeting notice was posted on November 2, 2012 in accordance with the posting policies and practices of Parkland. In addition, At the regular Dallas County Commissioners Court Meeting on November 6, the upcoming public meeting was highlighted and all interested parties were encouraged to attend for information and comment. Attendees were encouraged to directly questions and comments to the web site-let.

[41] Study: Dallas-Fort Worth lacks enough doctors to meet needs of growing population [http://www.dallasnews.com/health/headlines/20120522-study-dallas-fort-worth-lacks-enough-doctors-to-meet-needs-of-growing-population1.ece]

The materials presented in Appendix E-2 were posted on the Parkland Waiver website and distributed in hard copy to all meeting attendees. The public meeting was videotaped and is posted on You Tube[42]. As a result of the meeting, an article was written and appeared on the lower fold of the Dallas Morning News[43] front page and provided information to a very wide audience. The article is included in Appendix E-2. The draft plan to be submitted for Pass 1 was posted on the Parkland-sponsored website on November 15, 2012.

Pass 2 Public Meeting

To provide geographic access, the second public hearing was held in the Denton County Commissioners Court on December 18, 2012 at 6:30 p.m..

On December 11, 2012, the informal notice for the public meeting was distributed to each participant in the RHP requesting that the notice be widely distributed and posted throughout the region. The notice provided the URL for the Parkland web site-let for the Medicaid 1115 Waiver

The formal meeting notice was posted December 11, 2012 in accordance with the posting policies and practices of Parkland.

The materials presented in Appendix E-2 were posted on the Parkland Waiver website and distributed in hard copy to all meeting attendees. The draft plan to be submitted for Pass 2 was posted on the Parkland-sponsored website on December 18, 2012. The public meeting was videotaped and is posted on You Tube available through the Parkland 1115 Waiver website[44].

The Parkland web site-let for the Medicaid 1115 Waiver has a form by which the public can ask questions or post comments. No feedback was received through this channel from the point of the announcement of the public meeting to Pass 2 plan submission on December 31, 2012.

* * *

The Parkland web site-let will continue to post updates and remain available to receive public feedback throughout the period of plan review and finalization. RHP Nine will continue to update and engage stakeholders using a strategy that will be developed through the implementation organizational structure.

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[42] http://www.youttube.com/watch?v=2-drVYESODE

[43] Expanded Medicaid plan for Texas expected to improve access to care [http://www.dallasnews.com/news/community-news/dallas/headlines/20121108-expanded-medicaid-plan-for-texas-expected-to-improve-access-to-care.ece?action=reregister]

[44] http://www.parklandhospital.com/whoweare/section-1115/pass2-public-hearing.html

Section V. DSRIP Projects

Section V. DSRIP Projects

A. RHP Plan Development

Number of Category 1 and 2 Projects in RHP 9 Plan

RHP 9 is characterized as a Tier 2 Region in accordance with the Program Financing and Mechanics Protocol. As a Tier 2 Region, RHP 9 is required to include a minimum of 12 projects from Categories 1 and 2 combined, with at least 6 of the 12 projects selected from Category 2.

The following table presents the count of projects included in the Region 9 plan. Upon the completion of the First Pass, Region 9 far exceeded the Protocol requirement.

Projects	Pass 1	Passes 2 and 3	Total	Required
Category 1	31	13	44	-
Category 2	58	18	76	At Least 6
Total	89	31	120	Total 12

Project Development Process

As described in Section IV – Stakeholder Engagement, for the first half of calendar 2012 the RHP 9 DSRIP Task Force participants engaged actively in deliberations regarding potential DSRIP projects that would address identified community health needs and align with the DSRIP project menu. This work was intended to stimulate creative and collaborative project opportunities for RHP 9.

As the DSRIP project menus approached finalization, a broadly representative plan writing work group was formed to review, vet and formalize potential projects. At well-attended meetings on September 5, 2012 and September 11, 2012, RHP 9 performing providers formally presented to their regional peers their projects being considered for plan submission. Meeting participants provided constructive criticism, identified opportunities for collaboration and inter-entity project alignment. At the end of each of the two sessions, a representative from each participating organization submitted on behalf of his/her organization a project "grade" for each project. Subsequently the average grade for each project was tabulated and the results circulated. This transparent process produced significant shared learning, a collective awareness of the developing projects, and opportunities to improve each project.

Following the RHP 9 DSRIP review process, performing providers refined their projects and secured their IGT entity funding. To assure alignment with the intent of the waiver program and to provide information to support project valuation, all RHP 9 performing providers completed a project valuation worksheet. As described more fully in subsection B. below, the worksheet collected a self-assessment on the six dimensions that RHP 9 considered important including: Transformational Impact, Population Served/Project Size, Alignment with Community Needs, Cost Avoidance, Sustainability, and Partnership Collaboration.

RHP 9 Project Priorities

Upon completion of the Community Needs Assessment and in consultation with the DSRIP Task Force, the Community Needs Task Force identified seven priority areas that formed the nexus for shaping community goals. In consideration of the community needs, the intent of the waiver and the performing provider priorities, the RHP 9 participants shared a commitment to address the following:

- **Improving Access to Health Care Services** - for the region's most vulnerable populations with an emphasis on increasing capacity and reducing constraints in: Primary Care, Specialty Care, Behavioral Health Services, Palliative and Oral Health services. The delivery system will work to provide appropriate capacity so that patients can access the right care in the right setting at the right time avoiding care in more costly and less patient-centered settings.
- **Improve Coordination and Management of Care to the Individual Patient Across the Continuum** – so that patients can navigate the often complicated and fragmented delivery system which presents an even greater challenge to the most vulnerable patients. The Medical Home was embraced as the model that embodies the intent of a patient-centered approach to wellness, self-management and the prevention of disease exacerbation. RHP 9 believes that providing the connectivity among the health systems and care sites around the needs of the individual patient can yield tremendous benefits to the individual patient, the health of the population and to the community at large.
- **Improve Quality, Cost and Outcomes Performance of Health System Providers** – to improve the quality of care and services, improvem patient safety, reduce and/or eliminate harm to patients, provide an excellent patient experience and improve the cost effectiveness of care in all settings.

The RHP 9 participants believe that the three focal points outlined above are very consistent with the CMS triple aim to improve care for individuals (including access to care, quality of care and health outcome); improve health for the population; and lower costs through improvements (without any harm whatsoever to individuals, families or communities). The RHP 9 projects are designed to fit and promote one or more of the above three program goals.

Project Selection

To promote transparency within the region, RHP 9 established and hosted Sharepoint site. All projects and plan development materials have been filed on the shared site so that all RHP 9 participants can have access to and share information regarding all of RHP 9's projects. Through this approach, all RHP 9 participants have had full access to all of the plan development activities.

Through an iterative process, the early projects concepts have matured into the set of projects that have been submitted in the RHP 9 plan. Each project advances one or more of the three broad regional priorities described above. A complete list of projects developed, considered and selected for Passes 1, 2 and 3 are presented in Appendix F.

Process to Implement Pass 1, Pass 2 and Pass 3

Collectively, the RHP 9 participants reviewed the Program Funding and Mechanics Protocol to understand both its mechanics and intent. Before engaging in Pass 1, RHP 9 mapped out and modeled the full range of projects and participation for the DSRIP program that was desired by the region. Because of the particular circumstances regarding the MHMR funding in RHP 9, the RHP participants agreed to establish a "set aside" of approximately $60 million for future behavioral health projects to be developed, if possible, through the plan modification process. As the regional plan took shape, each performing provider entity reconfirmed the IGT commitment(s) for their DSRIP projects.

For Pass 1, those entities that were able to participate, submitted the projects that achieved their DSRIP objectives and aligned with their IGT capacity or committed support. Pass 1 proceeded in accordance with the expectations that had been mapped in advance.

In Pass 2, the additional entities that were eligible to engage submitted their projects. And, as anticipated, several Pass 1 performing providers submitted additional projects. To facilitate the additional Pass 2 participation, Parkland entered into collaboration agreements to assure that the allocated DSRIP dollars would be made available to support the desired projects.

For convenience, the Texas A&M Health Science Center, Baylor College of Dentistry participated in Pass 3. As a whole, the RHP 9 participants collaborated to assure that there was strong and broad participation in the DSRIP program.

Performing Providers Exempt from Category 4 Reporting

The table below lists the Performing Providers who are exempt from Category 4 reporting according to the criteria in paragraph 11.e. in the Program Funding and Mechanics Protocol.

Provider Type	TPI	Performing Provider
Physician Practice Plan Affiliated with an Academic Health Science Center	126686802	The University of Texas Southwestern Medical Center
County, Local Health Department	121758005	Dallas County Health and Human Services
County, Local Health Department	136360803	Denton County Health and Human Services
County MHMR	135234606	Denton County MHMR
County MHMR	137252607	Metrocare
County MHMR	121988304	Lakes Regional MHMR Center
Physician/Dentist Practice Plan Affiliated with an Academic Health Science Center	009784201	Texas A&M Health Science Center, Baylor College of Dentistry

B. Project Valuation

The RHP 9 Performing Providers considered a number of different valuation approaches that could be used as a general basis for the region. It was decided that an approach using a general value weighting process for all of the Region's Performing Providers could could be used as the primary or a supporting basis for each provider's project valuation. A worksheet tool was prepared to capture the relative value of each project and to create an overall weighted score for each project. The worksheet tool and related scoring guidance is presented in Appendix G. The table below presents the scoring and weighting design.

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%		
Population Served / Project Size	25%		
Alignment with Community Needs	20%		
Cost Avoidance	15%		
Sustainability	15%		
Partnership Collaboration	5%		

Performing providers completed the scoring tool for each project under consideration for inclusion in the plan. The weighted score was used as the basis for allocating each Pass 1 Hospital's funding allocation to potential DSRIP projects. The project-specific funding allocation information was shared among the performing providers so the values could be compared among like projects. Many providers augmented this method with several additional methods including:

- Detailed econometric models
- Consideration of outcomes related values
- Detailed assessment of returns on investment
- Valuation models collaboratively built specific to their provider types

There are variations in the project valuations, even among like types of projects, due to a number of factors and conditions including but not limited to the following:

- Geographic market segment targeted by the project
- Size and concentration of Medicaid and low-income patients to be served by the project
- Complexity of the project
- Scarcity of provider availability to implement the project
- Density or paucity of other health services in the area
- Priority and importance of the project to the provider with respect to achieving the Waiver priorities

Each performing provider considered and weighed the many factors surrounding valuation and submitted the project values that they believed best aligned with each project.

C. Category 1: Infrastructure Development

Project Option 1.1.1 – Establish More Primary Care Clinics

Unique Project ID: 195018001.1.1
Performing Provider/TPI: Trinity MC, LLC dba Baylor Medical Center at Carrollton/ 195018001

Provider: Baylor Medical Center at Carrollton is a 235-bed acute care facility located in Carrollton. The medical staff is comprised of over 500 physicians representing more than 50 specialties. Baylor Carrollton is a full service hospital providing comprehensive diagnostic, surgical, and medical care for inpatients and outpatients, as well as 24-hour emergency care. Baylor Carrollton's service area represents a population of 592,000.

Intervention(s): This project will implement a new Patient-Centered Medical Home (PCMH) clinic designed to provide comprehensive and high-quality primary care services to underserved (including Medicaid/Uninsured) patients in the Carrollton/Denton County service area.

New v. existing initiative: This project entails building a new PCMH clinic serving a new population of Uninsured and Medicaid patients in the Carrollton/Denton county area.

Need for the project: There are no clinics in the Carrollton area to provide primary care for the undeserved population. Access to quality primary care services has been demonstrated to improve health outcomes and reduce avoidable hospital utilization among underserved patient populations. This project will increase access to primary care for the underserved population.

Target population: The uninsured population in Denton County is 20.9% (equates to approximately 144,000 uninsured individuals). Clinic capacity will allow approximately 400 new patients per year to receive services. We expect that about 90-95% of the new patients/year will be uninsured/Medicaid patients.

Category 1 or 2 expected patient benefits: The project seeks provide a PCMH for 400 patients in DY4 and an additional 400 patients in DY5.

Category 3 outcomes: The Baylor Clinic at Carrollton will be a new clinic, therefore the metric baseline and projected achievements are estimates based off of historical performance from other Baylor Clinics.

- IT-1.7: Controlling High Blood Pressure. Our goal is to increase the number of patients with controlled blood pressure (< 140/80 mmHg) from 45.0% in DY4 to 50.4% (or 5.4% total improvement over established baseline) in DY5.

- IT-6.1: Percent Improvement over baseline of patient satisfaction scores (clinic wait times). Our goal is to increase patient satisfaction from 80% in DY4 to 82% in DY5 (or 2% improvement over established baseline).

- IT-6.1: Percent Improvement over baseline of patient satisfaction scores (timely response to patient phone calls). Our goal is to increase patient satisfaction from 85% in DY4 to 86.5% (or 1.6% improvement over baseline) in DY5.

- IT-12.1: Breast Cancer Screening. Our goal is to increase the number of appropriate women who receive breast cancer screenings from 38.3% in DY4 to 41.3% in DY5 (or 3% improvement over baseline)

- IT-12.5: Other USPSTF screening outcome (Influenza Vaccination). Goal is to increase the number of adults 18+ who receive influenza vaccination from 62% (DY4) to 63.9% in DY5 (or 1.9% improvement over baseline)

Project Description

This project would establish a new clinic for the underserved (including Medicaid/Uninsured) population on the Baylor Medical Center at Carrollton campus. Currently, there is no Baylor Clinic on the campus that serves the underserved population of Carrollton and surrounding communities. We would use existing space to furnish a primary care clinic leveraging and utilizing the standards, requirements and experience of similar Baylor Clinics on other Baylor campuses. This project is a brand new endeavor and requires infrastructure modifications/ construction,physician recruitment, staff and capital expenditures and we anticipate to be operational in late DY3/early DY4. We plan on starting to see patients in DY4. We expect that approximately 90-95% of new patients will be Medicaid/Uninsured. In addition to receiving primary care, this project also proposes that ancillary services such as labs, imaging (i.e.: CT scans, MRI, mammograms, ultrasound, echocardiograms, and interventional radiology) and diagnostics (i.e.: colonoscopy, stress tests, esophageal diagnostic, retinal screens) provided upon physician request. This project aims to provide a baseline of primary care availability, close the loop of care and increase patient compliance by co-locating/ coordinating many of the essential services that the underserved population often has issues accessing and completing.

Goals and Relationship to Regional Goals

The 5 year goals of this project are: (1) to build out, staff and establish a primary care clinic setting on the Baylor Medical Center at Carrollton campus, (2) to provide a primary care setting and PCP to a greater number of the underserved population in the Carrollton and Denton County areas, (3) provide volume relief to surrounding providers' EDs, (4) begin improve patients' health outcomes and status and (5) begin the creation of an integrated primary care model for underserved patients in Denton County to receive high quality, complete care keeping these patients from utilizing the emergency department for low acuity needs and preventing re(admissions) that could have been avoided with proper primary care.

The Region has a primary care provider and capacity issue for the underserved population. This issue is even more prevalent in Carrollton, where there is very little primary care availability for the underserved population. There are only 2 clinics available in the Carrollton area, creating access issues for patients in the community that are not near these clinics. This project will

increase access to primary care and provide high quality, comprehensive care to patients in a less costly setting. ED utilization is high in RHP 9 and by providing more patients with primary care they need, the goal is to keep them from using the ED as a means to receive basic care.

Challenges

Providers and hospitals are reluctant to expand primary care capacity in charity clinics due to the inherent necessity for other downstream services, procedures, and costs associated with adding a patient with multiple, complex needs from the underserved population. Additionally, there is not enough primary and specialty care providers and services supply to meet the demand from this population. Basic primary care needs are unable to be fulfilled because of the lack of funding and capacity to take more patients, thus leading to increased (re)admissions and prevalence of disease complications. Lastly, due to the transient nature of this population, it is difficult to achieve the full extent of quality and clinical outcomes associated with a Patient Centered Medical Home. This project addresses these challenges by creating a low-cost, effective, co-located and comprehensive model specifically for the underserved population.

5-year expected outcome for the performing provider and patients

At the end of 5-years, 800 new, unduplicated patients will have received PCMH/primary care services at the Baylor Clinics on the Baylor Medical Center at Carrollton Campus. We expect to be operational and seeing patients by DY4.

Starting point/baseline

There is no established baseline for this project. It is a new initiative on the Baylor Medical Center at Carrollton, where we will be establishing a new primary care clinic to care for the underserved population in Carrollton/Denton County. We do know that 20.9% of the population in Denton County is uninsured.[45] This equates to 144,000 patients in Denton County that do not have insurance and may need a PCP/primary care setting to receive care.[46] In addition, we know that there were over 14,000 Medicaid cases that presented to the Carrollton ED over the past 3 years. Lastly, Baylor Clinics that are similar in size and scope are able to serve anywhere from 600-1300 unduplicated patients per year. We anticipate that our volumes in DY4 and DY5 will be about 400 patients per year. We plan on recruiting patients directly from the Baylor Medical Center at Carrollton inpatient units and emergency department through a care navigation service located in the hospital as well as leveraging relationships with other community partners in Denton county.

Rationale

We chose this project option because of the demonstrated need in the RHP and to leverage our PCP/PCMH model to patients in the Carrollton area. According to the Community Health Needs

[45] Healthy People North Texas: http://www.healthyntexas.org

[46] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/48121.html

Assessment, 100% of the counties in the region are designated as medically underserved areas and 20.9% of individuals in Denton County are uninsured.[47] The combination of these two factors leads to increased ED utilization and clinical complications due to lack of adequate access to coordinated, primary care services. According to the Dallas Fort Worth Hospital Council database, 68% of ED visits related to the top conditions in the region was non-emergent /primary care treatable. The top five conditions from the ED that resulted in an inpatient admission were: stroke, diabetes, congestive heart failure, weak/failing kidneys, chronic bronchitis and heart attack. These services can be better coordinated and managed in a primary care setting, ensuring the patient 1) receives the care they need, 2) adequate follow-up is provided after these types of services are accessed and 3) providing these services in a timely fashion so that long term disease complications and other issues are avoided. Baylor Clinics have a proven track record for improving patient outcomes and creating primary care capacity in underserved areas. By leveraging this model and expertise a new primary care setting on the Baylor Carrollton campus would be a service to the community and to the patients.

Project Components

For this project, our plan is to focus on: 1) establish space, 2) recruit physicians, 3) develop clinic protocols and operational processes, 4) hire staff and make any capital investments, 5) recruit patients to be seen in the clinic. We will also engage in continuous quality improvement activities on a regular basis that focus on: 1) identifying key challenges with the expansion of this project, 2) determine opportunities to scale all or part of the project- depending on available resources and financial constraints and 3) look for ways to increase efficiency and effectiveness. These continuous quality improvement activities will be especially relevant as we establish the clinic and evaluate how to better serve the community and improve quality outcomes for the patients we see in the clinic.

Reasons for selecting the milestones and metrics

The chosen milestones and metrics are more heavily focused on process - establishing the clinic, infrastructure, processes and operations. In the latter years, the focus is on increasing the number of patients seen and to positively affect their clinical outcomes. We plan on measuring outcomes such as patient satisfaction, blood pressure, screenings and immunizations because they are a few of the core components of quality medical care for these underserved patients. We also plan on engaging in continuous quality improvement activities on a regular basis that focus on: 1) identifying key challenges with the expansion of this project and 2) determine opportunities to scale all or part of the project- depending on available resources and financial constraints and 3) look for ways to increase efficiency and effectiveness.

Unique community need identification number the project addresses:

CN.3- Healthcare Capacity

Describe how the project significantly enhances an existing delivery system reform initiative

[47] RHP 9 Community Health Needs Assessment

This project has not received any funding from any federal source. It enhances current delivery system reform initiative by focusing on providing high quality, low cost and comprehensive primary care services to the underserved population. It encourages decreased utilization of unnecessary specialty care, ED utilization and promotes better preventive services to avoid downstream complications and costs. It exemplifies the Triple Aim from the Institute of Healthcare Improvement's three components of better care, better health and lower cost.

Related Category 3 Outcome Measures

Note: For all of the below outcome measures, we are using estimates based on historical performance of other Baylor Clinics. Therefore, we may need to reevaluate these metrics and determine different thresholds once the clinic is operational in DY4. Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Outcome Measure #1: IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone measure). Controlling high blood pressure is essential in avoiding heart attacks, stroke, heart failure and a multitude of other diseases and complications. Through medication management, proper primary care attention and education, patients can achieve better blood pressure control in the outpatient setting. In Region 9, Hypertension was identified as one of the top 5 most prevalent diseases in the area for ED admissions[48]. A recent article in the New York Times suggested that hypertensive complications can be especially deadly in the African American population,[49] who make up 22.5% of the RHP 9 population and 9% of the Denton County population. Patients who are uncontrolled will receive the attention they need to get their hypertension under control.

Outcome Measure #2 and #3: IT-6.1 Percent Improvement over baseline of patient satisfaction scores (Standalone measure). Outcome Measure #2 will measure: *Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Clinic Wait Times.* Outcome Measure #3 will measure: *Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Response Time to Patient Phone Calls.* Establishing high patient satisfaction scores will be important at the Baylor Clinic on the Baylor Medical Center at Carrollton campus in order to ensure patients come and continue to come to the clinic to receive the care they need. We will be monitoring these metrics closely and evaluate improvements that may need to be made. We do not have a baseline for these metrics and have relied on historical performance and improvement opportunities of other Baylor Clinics on other Baylor campuses to shape our outcomes.

[48] RHP 9 Community Health Needs Assessment

[49] http://health.nytimes.com/health/guides/disease/hypertension/complications.html

Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Data from Press Ganey Associates in 2007[50] has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less physician/staff time, reducing length of visits and wait times for the overall practice. Baylor Clinics have historically had high performance in all measures related to patient satisfaction however there is opportunity for improvement. This outcome has an impact on the region through increasing utilization of outpatient based primary care. If patients are satisfied, they will continue to come to their appointments, stay healthier and stay out of the ED.

The following two outcome measures focus on adult preventive services. Adult Preventive services as recommended by USPSTF are low cost, highly effective interventions that prevent and maintain patients' health status. Again, because we do not have a baseline for any of these metrics, we have relied on historical performance of a similar Baylor Clinic on another campus. We believe these preventive screenings and services are an important part of basic primary care and have potential for immediate results in the short term time horizon.

Outcome Measure #4: IT-12.1 Breast Cancer Screening (Non-Standalone Measure). In Denton County, the incidence rate of breast cancer is 126.6 cases/100,000 females, much higher than the Dallas County rate of 23.7/100,000. This statistic is considered to be way higher than the national average. There is room for improvement with this metric to screen more women and utilize early detection methods for breast cancer.[51]

Outcome Measure #5: IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate). In Denton County, there are 32.6 deaths/100,000 people due to influenza and pneumonia. This rate is much higher than the national average of 19.6.[52] The rate of African American age adjusted death rate due to influenza/pneumonia is 70.8 deaths/ 100,000, two times greater than the Caucasian rate in Denton County.[53] The rate of influenza vaccinations in the Region is quite low and there is an opportunity to increase the number in the target population that receive this basic vaccination to prevent exacerbations of health issues, reduce the prevalence of influenza and prevent ED visits related to influenza that can otherwise be handled in an outpatient setting.

Relationship to other Projects

[50] Drain, M., Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.
[51] Healthy North Texas: www.healthyntexas.org
[52] RHP 9 Community Health Needs Assessment
[53] Healthy North Texas: www.healthyntexas.org

195018001.2.1 Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program. The Chronic Care model will be integrated into primary care to ensure that high risk patients with chronic disease would be identified, addressed and managed.

195018001.1.2- Improve Access to Specialty Care-Expand Specialty Care Services. Specialty services must be made available so patients can receive coordinated care/referrals to these services and necessary follow-up required for continuity of care in a primary care clinic setting.

Related Category 4 Population-focused improvements

RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.7, RD-1.8; RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7; RD-3.1, RD-3.5, RD-3.6, RD-3.10, RD-3.11, RD-3.22, RD-3.26, RD-3.36; RD-4.1, RD-4.2

Relationship to Other Performing Providers Projects and Plan for Learning Collaborative

Performing Provider	Unique Project
Baylor Medical Center at Garland	121790303.1.1
Baylor Medical Center at Irving	121776204.1.1
Baylor University Medical Center	195018001.1.1
Children's Medical Center	138910807.1.1
Children's Medical Center	138910807.1.2
Medical City Dallas (HCA)	020943901.1.3
Parkland Health & Hospital System	127295703.1.1
Parkland Health & Hospital System	127295703.1.2
Texas Health Presbyterian – Dallas	020908201.1.1
UT Southwestern Medical Center Faculty Plan	126686802.1.1
UT Southwestern Medical Center Faculty Plan	126686802.1.2

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. The exchange of best practices and shared learning contributes significantly to CQI and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Baylor Medical Center at Carrollton has computed the value of this project using the model developed

at the Regional level and has discounted the value since the new clinic will not be operational until DY3/early DY4.

Baylor Medical Center at Carrollton defined the population that will be directly impacted by the project as 800 underserved patients in the Carrollton area of the 144,000 uninsured in Denton County. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual, we concluded that, on a scale of 1 –5, the value of this project is a ***4.*** We believe this because the project entails providing a basic PCP/PCMH setting for underserved patients who do not have one. This alone has a large impact on the individual in being able to meet basic healthcare needs and receive necessary medical attention. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***4.*** We believe this to be the correct number because, when these patients receive healthcare, they are able to manage their conditions better and in a timely manner, remain productive members of society, stay out of the ED and avoid costly clinical exacerbations.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars, taking the regional cap of funding into consideration.

195018001.1.1	***1.1.1***	***CQI***	***ESTABLISH MORE PRIMARY CARE CLINICS-CREATE NEW BAYLOR CLINIC FOR UNDERSERVED***	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton				*195018001*
Related Category 3 Outcome Measure(s):	*195018001.3.1*	*3.IT-1.7*	*Controlling high blood pressure (Standalone measure)*	
	195018001.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores (Standalone)*	
	195018001.3.3	*3-IT-6.1*	*Percent improvement over baseline of patient satisfaction scores (Standalone)*	
	195018001.3.4	*3.IT-12.1*	*Breast Cancer Screening (Non-Standalone measure)*	
	195018001.3.5	*3.IT-12.5*	*Other USPSTF screening outcome (Influenza Vaccination) (Non-Standalone)*	

Year 2 (10/1/2012 – 9/30/2013)	**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]: Establish additional/expand existing/relocate primary care clinics Metric 1 [P-X.1]: Number of additional clinics or expanded hours or space Baseline/Goal: Determine location, size, scope of 1 new primary care clinic Data Source: Documentation of expansion/development plans Milestone 1 Estimated Incentive Payment: $ 287,004	**Milestone 2** [P-X]: Establish additional/expand existing/relocate primary care clinics Metric 1 [P-X.1]: Begin construction of new primary care clinic Baseline/Goal: Begin build out/renovation Data Source: Documentation of construction plans Milestone 2 Estimated Incentive Payment: $156,553 **Milestone 3** [P-5]: Train/hire additional primary care providers and staff and/or increase number of primary care clinics for existing providers Metric 1 [P-5.1]: Documentation of increased number of providers/staff and/or clinic sites Goal: Begin recruiting and hiring staff near the end of DY3. At minimum, this will include 3 new staff. Data Source: Employment agreements/offer letters to employees Milestone 3 Estimated Incentive Payment: $156,553	**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum 400 new patients will be seen at the Baylor Clinic (cumulative over baseline) Data Source: E.H.R Milestone 4 Estimated Incentive Payment: $314,016	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.2**]:** Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum 800 new patients will be seen at the Baylor Clinic (cumulative over baseline) Data Source: E.H.R Milestone 5 Estimated Incentive Payment: $259,404

195018001.1.1	***1.1.1***	***CQI***	***ESTABLISH MORE PRIMARY CARE CLINICS-CREATE NEW BAYLOR CLINIC FOR UNDERSERVED***	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton				*195018001*
Related Category 3 Outcome Measure(s):	*195018001.3.1*	*3.IT-1.7*	*Controlling high blood pressure (Standalone measure)*	
	195018001.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores (Standalone)*	
	195018001.3.3	*3-IT-6.1*	*Percent improvement over baseline of patient satisfaction scores (Standalone)*	
	195018001.3.4	*3.IT-12.1*	*Breast Cancer Screening (Non-Standalone measure)*	
	195018001.3.5	*3.IT-12.5*	*Other USPSTF screening outcome (Influenza Vaccination) (Non-Standalone)*	

Year 2 (10/1/2012 – 9/30/2013)	**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: $287,004	Year 3 Estimated Milestone Bundle Amount: $313,106	Year 4 Estimated Milestone Bundle Amount: $314,016	Year 5 Estimated Milestone Bundle Amount: $259,404
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,173,530			

Project Option 1.9.2 - Improve Access to Specialty Care-Expand Specialty Care Services

Unique Project ID: 195018001.1.2
Performing Provider/TPI: Trinity MC, LLC dba Baylor Medical Center at Carrollton/ 195018001

Provider: Baylor Medical Center at Carrollton is a 235-bed acute care facility located in Carrollton. Baylor Carrollton provides a broad spectrum of medical and health care services to the people of North Dallas. The medical staff is comprised of over 500 physicians representing more than 50 specialties. Baylor Carrollton is a full service hospital providing comprehensive diagnostic, surgical, and medical care for inpatients and outpatients, as well as 24-hour emergency care. Baylor Carrollton's service area represents a population of 592,000.

Intervention(s): This project will increase access to needed specialty care services (i.e. outpatient visits with specialty physicians, hospital-based procedures) for uninsured patients under the care of the new Baylor Clinic in Carrollton.

New v. existing initiative: This is a new project to Baylor Carrollton and will provide access to specialty care services previously unattainable for Medicaid/Uninsured patients.

Need for the project: Specialty services are a key element to providing a full continuum of care to patients (beyond what can be provided in a primary care clinic) and an important contributor to improved health outcomes and avoidance of costly clinical exacerbations. Shortage of specialty care was one of the key health needs identified in the RHP.

Target population: The target population will be a subset of established Baylor clinic patients who require specialty services. While historical data suggests 10-15% of all established patients will develop a need for specialty services, constraints in available specialists and facilities should allow the project to serve approximately 5% of all established patients within a given year. At least 90% of patients served in this project will be Medicaid/Uninsured.

Category 1 or 2 expected patient benefits: The specialty care project in Carrollton will not be implemented until DY4. Over the course of DY4 and DY5 an estimated 50 individual patients will be connected to specialty care services.

Category 3 outcomes: The Baylor Clinic at Carrollton will be a new clinic, therefore the metric baseline and projected achievements are estimates based off of historical performance from other Baylor Clinics:

- IT-11.1: Improvement in Clinical Indicator in identified disparity group: Improvement in Asthma metrics. Our goal is to improve performance of our Asthma metrics Percent of Opportunities Achieved (POA) to 30% (or 10% improvement over established baseline) completed in DY5.

- IT-12.2: Cervical Cancer Screening. Our goal is to increase the number of appropriate women receive screenings from 52.5% in DY4 to 54.9% in DY5 (or a minimum of 2.4% improvement over baseline).

- IT-12.3: Colorectal Cancer Screening. Our goal is to increase the percentage of appropriate patients receive screenings from 24% in DY4 to 27.8% in DY5 (or a minimum of 3.8% improvement over baseline).

Project Description

Patients (including Medicaid and Uninsured) who are seen at a Baylor Clinic and have established primary care there, can receive the following specialty care services: certain outpatient procedures such as: office visits with specialists, wound care, and facility based procedures such as cardiac catheterizations, certain surgeries (i.e.: gall bladder/hernia), excision of masses (breast, lymphoma), and cataract removal. This project excludes transplants, oncology and perinatal services. The specialty care referral and coordination would come from the clinic per request by the patient's PCP. These services would not be available until DY4 when the Baylor Clinic on the Baylor Medical Center at Carrollton is operational.

Goals and Relationship to Regional Goals

The goals for this project are to 1) increase/improve access to specialty care services, 2) engage a greater number of providers/facilities to provide these services, 3) increase the number of completed specialty referrals for patients and 4) improve disease specific clinical outcomes affected by increased access to target specialists. As a result, we expect that more patients will have a better quality of life when they are given the appropriate specialty care, in a timely manner and in the appropriate venue. By managing the patient and coordinating the care through the primary care clinic, we expect the patient will have fewer complications post procedure. Because these specialty care services will not start until DY4, we hope to establish a level of care in the community during the remaining years in the waiver. Depending on the community need, outcomes and improvements may vary. According to the Community Health Needs Assessment, the demand for primary and specialty care services exceeds that of available physicians, thus limiting healthcare access for many low level management or specialized treatments for health conditions[54]. This project would help to offset some of the demand for specialty care services and do so in a coordinated and meaningful way. The patients who need specialty care services, both inpatient and outpatient, would require a referral from their Baylor Clinic to receive the procedure and then also be able to follow-up with their PCP after the procedure/test is completed. This synchronizes with the regional needs of providing access to more specialty care and also coordinates the care for the patient to ensure compliance timely care. As patients receive the specialty care they need, it is likely that clinical

[54] RHP 9 Community Health Needs Assessment

exacerbations of manageable conditions will decrease, lowering the cost of care in more expensive settings.

Challenges

The major challenges with providing increased access to specialty care are multiple: 1) lack of supply of specialty providers in the Region and even smaller supply who are willing to provide specialty care services to this population, 2) specialty care is expensive to provide for patients who have little or no ability to pay. Major procedures/surgeries can be a financial burden for performing providers and related entities, 3) there is often a long wait list for patients to receive specialty care, leading to clinical exacerbations due to less timely care and 4) there is no coordination or follow-up for patients who do receive specialty care leading to infections, healing issues and lack of wound management which can often lead to a (re)admission to the hospital. Through developing community relationships with providers and facilities in the area, we plan to find ways to provide more access points for these patients to receive the care they need, in a timely manner so that we are can monitor utilization and outcomes to be good stewards of the limited specialty care resources available in the Region.

5-year expected outcome for the performing provider and patients

The 5 year expected outcome of increasing access to specialty care is to provide specialty care to approximately 54 unduplicated patients over the waiver period through increasing the number of providers/facilities contracted to at least 6. Lastly, we expect to begin to help facilitate the coordination and collaboration of specialists and primary care providers for our patients. We hope that by engaging specialists to do more complex procedures as well as preventive services that this will help create a more robust care team that will benefit the entire community. Because these services will begin in DY4, it is possible that these expectations will occur toward the end of DY5 and beyond the waiver period.

Starting Point/ Baseline

Currently, there are no specialty care referrals provided for the underserved population in Carrollton. The baseline, therefore has not been closely tracked. A major focus of this project will be to more accurately capture baseline data and formalize the specialty care referral process starting in DY4. Historic data on specialty care demand amongst Baylor Clinic patients suggests that 10-15% of all patients develop a need for specialty care services at some point in their care. The constraints of limited specialty care providers and facilities willing to care for this population have allowed similar programs in the area to meet demand for approximately 5% of a clinic's patient population.

Rationale

A key strategy for the Baylor Clinics has been the expansion and establishment of primary care access for the underserved population. Increased access to primary care has been strongly correlated with better health outcomes and lower avoidable hospital utilization within this patient population. While primary care providers are able to manage and treat many conditions, historic experience suggests that 10-15% of a clinic's patient population will likely develop a specialty care need at some point. Left untreated, this 10-15% of patients is likely to develop further exacerbation of health problems, experience more complications and increase the likelihood of avoidable hospital utilization. Additionally, as part of an effort to create a complete and robust care team for our patients, making specialty care part of that team is essential. We chose this project option to supplement our latter goal of engaging specialty care physicians in providing the more complex and advanced procedures/screenings but also to conduct some basic preventive screenings and education for the patient. We feel that this will make specialists a formal part of the overall care team. The new Baylor Clinic at Carrollton will have to establish relationships with providers in the community and as the clinic grows, we plan to leverage and expand those relationships in order to serve more of our patients. As Baylor Clinics take on more patients from the community, we anticipate that there will be an increased need for specialty care services in this population. This project proactively creates increased specialty access for these new patients as well established clinic patients who have historically had poor access to specialty care.

Project Components

We will complete all required project components for the expansion of specialty care project:

a) Increase service availability with extended hours: we will increase service availability by offering more appointments to patients in the outpatient setting and coordinate with surrounding hospitals to provide the inpatient services the patient may need

b) Increase number of specialty clinic locations: we plan to contract with at least 6 providers/facilities over the course of the waiver, providing more locations for patients to receive the specialty care they need

c) Implement transparent, standardized referral processes across system: we already have a standard referral form and process which is documented in the EHR and is visible to staff; but we will work to improve tracking, reporting and collection of referral data

d) Conduct quality improvement for project using methods such as rapid cycle improvement: we will engage in 1) identifying key challenges with the expansion of this project, 2) determine opportunities to scale all or part of the project- depending on available resources and financial constraints, 3) find ways to integrate the specialist into the care team as much as possible.

The milestones and metrics chosen for this project really focus on developing a baseline of specialty care for underserved patients in Carrollton. Improvement of coordinating the care for patients to receive specialty care and more of it will come in the latter years once patients are seen at the Baylor Clinic and begin to receive specialty care services. The Region has demonstrated a need to improve access to specialty care and fulfill some of the gaps that have been identified in the care that is unavailable. Our metrics and milestones are structured as such and the specialties identified will be a priority as the project progresses and more facilities/providers are contracted with to provide these services. Other metrics focus on increasing the number of appropriate referrals which entails identifying patients early on when certain minor procedures can be completed in lieu of more expensive alternatives. Lastly, we have set specific metrics around the number of patients who will be served to ensure that actual patient lives are impacted and specialty care is delivered to these individuals.

Unique community need identification number the project addresses

CN.3- Healthcare Capacity, CN.9- Specialty Care

How the project significantly enhances an existing delivery system reform initiative

This project does not receive any source of federal funding and has been identified as a significant Regional need. It enhances the existing delivery system reform initiative by coordinating specialty care through a primary care setting; thus managing utilization, costs and reducing complications for patients. This project would supply the specialty care needs identified by the Region and individual providers but also ensures that utilization is controlled.

Related Outcome Measures

Based on our projected ability to contract with certain specialists available in the area, we have chosen outcome measures below that will be addressed upon establishing relationships with the specialties mentioned below. Also, these services will not begin until DY4 and the outcome measures below are based off of previous historical performance of similar Baylor Clinics during their preliminary years of operation.

Outcome Measure #1: IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (Standalone measure). We plan on measuring the improvement in Asthma for Baylor Clinic patients. Asthma affects about 19.6% of the Dallas County population and was identified as one of the top five conditions for cause of ED visits in the Region. Approximately 90.1% of these ED visits related to Asthma could have been handled in the outpatient setting. [55] At Baylor Health Care System, we have standard Asthma metrics: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. We measure this yearly for our Asthma patients and calculate what we call: The Percent of Opportunity Achieved (POA). This is calculated by dividing the total number of services or

[55] RHP 9 Community Health Needs Assessment

targets achieved over the total number of eligible services or targets within a sample population. POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in asthma management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their asthma patients than in the prior reporting period. For an illustrative example: For Asthma- there are 4 opportunities (i.e. metrics) per patient (1) documentation of Action/Mgmt Plan, 2) Severity Assessment, 3) Controller Therapy for those who are eligible, and 4) Spirometry within last two years). The denominator would be # of patients x 4. So, for example, if there are 10 patients x 4 opportunities each = 40 opportunities to be achieved. If, in the course of the year, only 30 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 30/40=75%. To achieve a 10% improvement in POA, we would have to have completed at least 34/40 opportunities to get at 85% achievement.

Outcome Measure #1: IT-12.2 Cervical Cancer Screening (Non-Standalone Measure). In Region 9, the incidence rate of cervical cancer is higher than the national average. In Denton County, the incidence rate of cervical cancer is 5.9 cases per 100,000 people.[56]According to the National Cancer Institute, African American women are more likely to be diagnosed with cervical cancer and Hispanic women have the highest cervical cancer incidence rate amongst all women[57]. There is opportunity to increase screenings in the minority population through engaging OB/GYNs to provide screenings/education for this population. Additionally, these specialists can provide advanced screenings/education that would not be available in primary care settings.

Outcome Measure #2: IT-12.3 Colorectal cancer screening (Non-Standalone Measure). In Denton County the incidence rate of colorectal cancer is 40.0 cases per 100,000. It is the second leading cause of cancer related deaths in the US and as many as 60% of the deaths from colorectal cancer could be avoided with regular screening tests.[58] There is a definite need for these services in Denton County and the Baylor Clinic plans to provide these screenings to a greater number of people. There is greater need for patients to receive (appropriate) sigmoidoscopies/ colonoscopies in the region as a preventive measure. According to the Centers for Disease Control and Prevention, Hispanics and African Americans are less likely to get screened for colorectal cancer and it is often found in the latter stages of the disease as compared to their Caucasian counterparts.[59] There is an opportunity to increase the colorectal cancer screening rates by engaging specialists in the Denton County area to provide these basic and advanced screenings along with education that is focused on this particular topic.

Relationship to other Projects

[56] Healthy People North Texas: http://www.healthyntexas.org

[7] National Cancer Institute: http://www.cancer.gov/

[58] Healthy People North Texas: http://www.healthyntexas.org

[59] Centers for Disease Control and Prevention: http://www.cdc.gov/

Increasing access to specialty care is related to the project of expanding primary care capacity for two reasons: 1) as more patients enter the PCMH, there will be an increase in the need for specialty care services and 2) primary care is essential to coordinate the specialty care and to allow for adequate follow-up for the patient, in order to avoid any complications or issues that may arise after the specialty care is received

Related Category 4 Population-focused improvements

Many of the metrics listed here can be avoided or be less severe with adequate primary care follow up. While complications and failures that occur in the hospital cannot be avoided through just providing specialty care, many of the post-operative and minor procedures can be handled in the outpatient setting. Some of the inpatient specialty care proposed to be provided under this project would directly be tied to some of the Category 4 metrics.

RD-1.1, RD-1.4, RD-2.1, RD-2.4, RD-2.5, RD.2.7; RD-3.1, RD-3.3, RD-3.4, RD-3.5, RD-3.7, RD-3.8, RD-3.10, RD-3.11, RD-3.13, RD-3.14, RD-3.15, RD-3.16, RD-3.20, RD-3.21, RD-3.22, RD-3.27, RD-3.37, RD-3.38, RD-3.40, RD-3.41, RD-3.44, RD-3.45, RD-3.36, RD-3.48, RD-3.51, RD-3.52, RD-3.53, RD-4.1, RD-4.2

Relationship to Other Projects

In addition to Baylor Medical Center at Carrollton (Trinity), projects to expand specialty care are submitted by the following system entities:

- Baylor Medical Center at Garland: 121790303.1.2
- Baylor Medical Center at Irving: 121776204.1.2
- Baylor University Medical Center: 195018001.1.2

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

The following providers have projects to expand specialty care access:

- Parkland Health & Hospital Center – 127295703.1.5
- UT Southwestern – Faculty Practice Plan – 126686802.1.5

Our project aims to open access to patients who could not otherwise receive the specialty care they need and will require coordination and collaboration with other performing providers in the region. Our project does not 1) serve the same specialty care population as the aforementioned projects and 2) we plan on having a broader scope of specialty care services offered through our Baylor Clinic

Plan for Learning Collaborative. We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain

additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. This methodology is consistent with our approach in our other RHPs*. Baylor Medical Center at Carrollton has* computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor Medical Center at Carrollton defined the population that will be directly impacted by the project as *underserved individuals in the Carrollton and Denton County area* that access to specialty care services. People who receive these services must be a patient of the Baylor Clinic prior to being referred to specialty care. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual, we concluded that, on a scale of 1 –5, the value of this project is a ***3.***We believe this to be the correct number because, when a person is positively impacted, their ability to maintain their health and address their complex health needs will be addressed. People will receive the procedures, diagnostics, etc. that they previously were unable to afford or could not have access to. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1-5, the value of this project is a *3.* We believe this to be the correct number because, when a person is positively impacted, clinical exacerbations are lessened and they incur less costly procedures/surgeries versus waiting for specialty care and having a more serious condition occur.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we allocated dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of dollars taking the regional cap of funding into consideration.

195018001.1.2	***1.9.2***	***1.9.2 (A-D)***	***IMPROVE ACCESS TO SPECIALTY CARE-*** EXPAND SPECIALTY CARE SERVICES	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton				*195018001*
Related Category 3 Outcome Measure(s):	*195018001.3.11* *195018001.3.6* *195018001.3.7*	*3.IT-11.1* *3.IT-12.2* *3.IT-12.3*	*Improvement in Clinical indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined- Asthma improvement (Standalone measure)* *Cervical cancer screening (Non-Standalone Measure)* *Colorectal cancer screening (Non-Standalone Measure)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct specialty care gap assessment based on community need Metric 1 [P-1.1]: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline/Goal: Documentation of gap assessment based on Baylor Clinic patient need and how this coincides with Regional needs Data Source: Documentation of specialty care need Milestone 1 Estimated Incentive Payment *(maximum amount):* $59,792	**Milestone 2** [P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties Metric 1 [P-2.1]: Training of staff and providers on referral guidelines, processes and technology Baseline/Goal: Train hired staff and providers trained Data Source: Signed documentation of training or in service Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 32,615 **Milestone 3** [P-6]: Develop and implement standardized referral and work-up guidelines Metric 1 [P-6.1]: Referral and work up guidelines Baseline/Goal: Develop guidelines and referral processes Data Source: Documentation of processes and guidelines		**Milestone 4** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 3 providers or facilities to provide specialty care services (over DY2) Data Source: Documentation of implemented contracts Milestone 4 Estimated Incentive Payment: $ 32,710 **Milestone 5** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2).	**Milestone 6** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 6 providers or facilities to provide specialty care services (over DY2) Data Source: Documentation of implemented contracts Milestone 6 Estimated Incentive Payment: $ 27,021 **Milestone 7** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2).

195018001.1.2	***1.9.2***	***1.9.2 (A-D)***	***IMPROVE ACCESS TO SPECIALTY CARE-*** EXPAND SPECIALTY CARE SERVICES	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton				*195018001*
Related Category 3 Outcome Measure(s):	*195018001.3.11* *195018001.3.6* *195018001.3.7*	*3.IT-11.1* *3.IT-12.2* *3.IT-12.3*	*Improvement in Clinical indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined- Asthma improvement (Standalone measure)* *Cervical cancer screening (Non-Standalone Measure)* *Colorectal cancer screening (Non-Standalone Measure)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 32,615	Goal: Provide at least 20 unduplicated patients with specialty care services over DY2 Data Source: E.H.R Milestone 5 Estimated Incentive Payment: $32,710	Goal: Provide at least **54** unduplicated patients with specialty care services over DY2 Data Source: E.H.R Milestone 7 Estimated Incentive Payment: $ 27,022
Year 2 Estimated Milestone Bundle Amount: $59,792		Year 3 Estimated Milestone Bundle Amount: $65,230	Year 4 Estimated Milestone Bundle Amount: 65,420	Year 5 Estimated Milestone Bundle Amount: $54,043
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $244,485				

Project Option 1.1.2 - Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

Unique Project ID: 121790303.1.1
Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Provider: Baylor Medical Center at Garland is a fully accredited, 240-bed medical center serving the residents of Garland, Texas, and the neighboring communities. Baylor Garland has 582 physicians on its medical staff representing a wide range of specialties. Baylor Garland's service area represents a population of 640,000.

Intervention(s): This project will implement increased access to two Patient-Centered Medical Home (PCMH) clinics designed to provide comprehensive and high-quality primary care services to underserved patients in the Baylor Medical Center at Garland service area The project is an expansion of Baylor's Clinic strategy in Garland and Dallas County. Historically, Baylor's Community Care clinics have provided access to patients following discharge from Baylor Medical Center at Garland. This expansion will focus on the recruitment of more underserved (Medicaid/Uninsured) patients from the community at-large and patients awaiting access to other public resources.

Need for the project: Access to quality primary care services has been demonstrated to improve health outcomes and reduce avoidable hospital utilization among underserved patient populations. This project will increase access to a PCMH for more patients in the community. .

Target population: The 872,000 uninsured and Medicaid population in Dallas County without a PCP/PCMH. Clinic capacity will allow approximately 600 new patients/year to receive services. We expect that about 90-95% of the new patients/year will be uninsured/Medicaid patients.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide access to an anticipated 1,700 new patients from the Garland community.

Category 3 outcomes: Category 3 outcomes for this project were chosen because: 1) the ambulatory setting of the project and 2) historical trends of metrics that had material impact on patients in a 2-3 year time period. All baselines will be reevaluated and reestablished in DY2

- IT-1.7: Controlling High Blood Pressure. Our goal is to increase the number of patients with controlled blood pressure (< 140/80 mmHg) from 47.3% currently to 54.8% (or a total of 7.5% improvement over baseline) in DY5.
- IT-6.1: Percent Improvement over baseline of patient satisfaction scores (clinic wait times). Our goal is to increase patient satisfaction from 86.8% currently to 88.7% in DY5 (or a total of 1.9% improvement over baseline).

- IT-6.1: Percent Improvement over baseline of patient satisfaction scores (timely response to patient phone calls). Our goal is to increase patient satisfaction from 90.3% currently to 91.7% (or a total of 1.4% improvement over baseline) in DY5.

- IT-12.1: Breast Cancer Screening. Our goal is to increase the number of appropriate women who receive breast cancer screenings from 37.8% currently to 46.7% in DY5 (or a total of 8.9% improvement over baseline)

- IT-12.5: Other USPSTF screening outcome (Influenza Vaccination). Goal is to increase the number of adults 18+ who receive influenza vaccination from 61.1% to 66.6% (or a total of 5% improvement over baseline) in DY5.

Project Description

The Baylor Clinic on the Baylor Medical Center at Garland campus, would expand their current capacity by opening their patient panels to non-Baylor patients (including Medicaid and Uninsured) and fully utilize the space and providers' capacity. Additional support staff will be hired to better coordinate patient care, ensure transition from the hospital to a Baylor Clinic and help to facilitate the care of the complex underserved patients. The Baylor Clinic on the Baylor Medical Center at Garland is already an NCQA recognized PCMH, thus the focus of this project would be to open the current panel to the underserved community and provide volume relief for other providers/ health systems in the area. We expect that approximately 90-95% of new patients will be Medicaid/Uninsured. Additionally, the clinic would provide these high quality primary care services to a greater number of people. In addition to receiving primary care, this project also proposes that ancillary services such as labs, imaging (i.e. CT scans, MRI, etc.) and diagnostics (i.e. colonoscopy, stress tests, retinal screens, etc.) would also be provided upon physician request. This project aims to close the loop of care and increase patient compliance by co-locating/coordinating many of the essential services that the underserved population often has issues accessing and completing.

Goals and Relationship to Regional Goals

The 5 year goals of this project are: (1) to provide a PCMH and PCP to a greater number of the Garland area underserved population, (2) provide continuity and transition to post-acute care services, (3) improve patients' health outcomes and status (4) create an integrated primary care model for underserved patients in Dallas County to receive high quality, complete care keeping these patients from utilizing the emergency department for low acuity needs and preventing re(admissions) that could have been avoided with proper primary care. The Region has a primary care provider and capacity issue for the underserved population. This project aims to address increasing access to primary care and providing high quality, comprehensive care to patients in a less costly setting. Emergency Department utilization is high in RHP 9 and by providing more patients with the primary care they need, the goal is to keep them from using the ED as a means to receive basic care.

Challenges

Providers and hospitals are reluctant to expand primary care capacity in charity clinics due to the inherent necessity for other downstream services, procedures, and costs associated with adding a patient with multiple, complex needs from the underserved population. Basic primary care needs are unable to be fulfilled because of the lack of funding and capacity to take more patients, thus leading to increased (re)admissions and prevalence of disease complications. Lastly, due to the transient nature of this population, it is difficult to achieve the full extent of quality and clinical outcomes associated with a Patient Centered Medical Home. This project addresses these challenges by creating a low-cost, effective, co-located and comprehensive model specifically for the underserved population.

5-year expected outcome for the performing provider and patients

At the end of 5-years, 1700 new, unduplicated patients will have received PCMH/primary care services at the Baylor Clinics on the Baylor Medical Center at Garland Campus. We expect that at least 15% of patients who continue to come to the Baylor Clinics will achieve better Adult Preventive Scores (APS) and have overall better clinical outcomes.

Starting point/baseline

From July 2010 to June 2011, the Baylor Clinics on the Baylor Medical Center at Garland served over 870 unduplicated patients. To date, there has not been a formal process to take patients from the community; capacity is typically reserved for those patients that come from a Baylor Medical Center at Garland ED. In addition to patients discharged from Baylor Medical Center at Garland, we will focus on 1,700 of the 872,000 uninsured patients in Dallas County.[60] We plan on recruiting patients into our Baylor Clinics through a combination of utilizing our inpatient care navigation services and furthering relationships with community partners. Currently, we have Care Navigators which proactively identify potential hospital patients that would be candidates to be seen in a Baylor Clinic. Also, through the creation of project 121790303.2.3 (navigation services for high risk patients), will provide additional patients to be seen at the Baylor Clinic. Lastly, our relationship with other providers and community partners will also serve as a referral source into the clinic.

Rationale

We chose this project option because of the demonstrated need in the RHP and to leverage our PCP/PCMH model to patients outside of Baylor. According to the Community Health Needs Assessment, 100% of the counties in the region are designated as medically underserved areas and 36.1% of individuals in Dallas County are uninsured.[61] The combination of these two factors leads to increased ED utilization and clinical complications due to lack of adequate access to coordinated, primary care services. According to the Dallas Fort Worth Hospital Council database, 68% of ED visits related to the top conditions in the county were non-emergent / primary care treatable. The top five conditions from the ED that resulted in an inpatient admission were: stroke, diabetes, congestive heart failure, weak/failing kidneys, chronic

[60] http://quickfacts.census.gov/qfd/states/48/48439.html

[61] RHP 9 Community Health Needs Assessment

bronchitis and heart attack. These services can be better managed in a primary care setting, ensuring 1) the patient receives the care they need, 2) adequate follow-up is provided after these types of services are accessed and 3) services are provided in a timely fashion so that long term disease complications are avoided. Baylor Clinics have a proven track record for improving patient outcomes and creating primary care capacity in underserved areas. Extending this model of care to non-Baylor patients would be a service to the community and patients. This project is a low-cost, high-quality solution to a pressing need in the community.

Project Components

a) *Expand primary care clinic space:* We will not be physically expanding the primary care clinic space, but we will be more fully utilizing the current space we have and will take advantage of underutilized space in the Baylor Clinic to see more patients. By carving out space to handle non-clinical needs such as finding community resources, education, coordinating care/appointments, etc., this will allow more room for providers to see patients and handle clinical needs.

b) *Expand primary care clinic hours:* We plan to expand our hours through the expansion of care teams. By adding (or modifying current roles of) mid-levels and other non-physician support staff, there will be more provider hours available, more appointment availability through expanding our current capacity from two appointment slots an hour to four (for example).

c) *Expand primary care clinic staffing*. We plan on hiring at least 2 FTEs to add to the care team in Irving in order to increase our capacity and services offered. We also plan to make the current staff hours more efficient so that more appointments per hour can be offered to patients.

The milestones and metrics that were chosen for this project are more heavily focused on improvement rather than process because much of the infrastructure and logistics are already in place because of the NCQA requirements for PCMH recognition. The Baylor Clinics at Baylor Medical Center at Garland are NCQA recognized[62], thus the focus of the metrics is on further improving and refining the PCMH baseline that has been established. Improvement metrics that hone in on increasing capacity, patient satisfaction and serving more patients are the impetus of this project. We also plan on engaging in continuous quality improvement activities on a regular basis that focus on: 1) identifying key challenges with the expansion of this project, 2) determine opportunities to scale all or part of the project- depending on available resources and financial constraints and 3) look for ways to increase efficiency and effectiveness.

Unique community need identification number the project addresses:

CN.3- Healthcare Capacity, CN.12-ED Usage and Readmissions

Describe how the project significantly enhances an existing delivery system reform initiative

[62] NCQA: http://www.ncqa.org

This project has not received any funding from any federal source. It enhances current delivery system reform initiative by focusing on providing high quality, low cost and comprehensive services to the underserved population. It encourages decreased utilization of unnecessary specialty care, ED utilization and promotes better preventive services to avoid downstream complications and costs. It exemplifies the Triple Aim from the Institute of Healthcare Improvement's three components of better care, better health and lower cost.

Related Category 3 Outcome Measures

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients got a PCMH at a Baylor Clinic.

Outcome Measure #1: IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone measure). Controlling high blood pressure is essential in avoiding heart attacks, stroke, heart failure and a multitude of other diseases and complications. Through medication management, proper primary care attention and education, patients can achieve better blood pressure control in the outpatient setting. In Region 9, Hypertension was identified as one of the top 5 most prevalent diseases in the area for ED admissions[63]. A recent article in the New York Times suggested that hypertensive complications can be especially deadly in the African American population,[64] who make up 22.5% of the RHP 9 population[65] and 14.5% of the Garland population.[66] Patients who are uncontrolled will receive the attention they need to get their hypertension under control. Patients will receive medication management, lifestyle management techniques and education about their illness in this clinic PCMH setting.

Outcome Measure #2, #3: IT-6.1 Percent Improvement over baseline of patient satisfaction scores (Standalone measure). Standalone measure). Outcome Measure #2 will measure: *Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Clinic Wait Times.* Outcome Measure #3 will measure: *Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Response Time to Patient Phone Calls.* Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Data from Press Ganey Associates in 2007[67] has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less

[63] RHP 9 Community Health Needs Assessment

[64] http://health.nytimes.com/health/guides/disease/hypertension/complications.html

[65] RHP 9 Community Health Needs Assessment

[66] Census Quick Track: http://quickfacts.census.gov/qfd/states/48/4829000.html

[67] Drain, M., Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

physician/staff time, reducing length of visits and wait times for the overall practice. Baylor Clinics have historically had high performance in all measures related to patient satisfaction, however there is opportunity for improvement. This outcome has an impact on the region through increasing utilization of outpatient based primary care. If patients are satisfied, they will continue to come to their appointments, stay healthier and stay out of the ED.

The following outcome measures focus on adult preventive services. Adult Preventive services as recommended by USPSTF are low cost, highly effective interventions that prevent and maintain patients' health status.

Outcome Measure #4: IT-12.1 Breast Cancer Screening (Non-Standalone Measure). In Dallas County, 23.7/100,000 women die from breast cancer with the rate in African American at 37/100,000. This statistic is considered to be higher than the national average. There is room for improvement with this metric to screen more women and utilize early detection methods for breast cancer.[68]

Outcome Measure #5: IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate). In Dallas County, only 65% of individuals over the age of 18 received an influenza vaccination in the past 12 months[69]. The rate of influenza vaccinations in the Region is quite low and there is an opportunity to increase the number in the target population that receive this basic vaccination in order to prevent exacerbations of health issues, reduce the prevalence of influenza and prevent ED visits related to influenza that can otherwise be handled in an outpatient setting.

Relationship to other Projects

121790303.2.1 Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program: The Chronic Care Management model will be integrated to ensure that high risk patients with chronic disease would be identified, addressed and managed.

PASS 2: 121790303.2.4 Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs - Vulnerable Patient Network (Home Visit Program)

121790303.1.2- Improve Access to Specialty Care-Expand Specialty Care Services: Improving access to specialty care is essential so patients can receive coordinated care/referrals to these services and necessary follow-up required for continuity of care in a primary care clinic setting.

121790303.2.2- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment

[68] Healthy North Texas: www.healthyntexas.org

[69] RHP 9 Community Health Needs Assessment

The project involving developing care management functions to integrate primary and behavioral health needs of individuals will provide co-located patient care services.

Related Category 4 Population-focused improvements

RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.7, RD-1.8; RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7; RD-3.1, RD-3.5, RD-3.6, RD-3.10, RD-3.11, RD-3.22, RD-3.26, RD-3.36; RD-4.1, RD-4.2

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

Other projects focusing on the expansion of primary care include:

Performing Provider	Unique Project ID
Baylor Medical Center at Irving	121776204.1.1
Baylor Medical Center at Carrollton (Trinity)	195018001.1.1
Baylor University Medical Center	139485012.1.1
Children's Medical Center	138910807.1.1
Children's Medical Center	138910807.1.2
Medical City Dallas (HCA)	020943901.1.3
Parkland Health & Hospital System	127295703.1.1
Parkland Health & Hospital System	127295703.1.2
Parkland Health & Hospital System	127295703.1.6
Parkland Health & Hospital System	127295703.1.1
Texas Health Presbyterian – Dallas	020908201.1.1
UT Southwestern Medical Center Faculty Plan	126686802.1.1
UT Southwestern Medical Center Faculty Plan	126686802.1.2

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. This methodology is consistent with our approach in our other RHPs. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor Medical Center at Garland defined the population that will be directly impacted by the project as *1700 underserved patients in the Dallas area of the 872,000+ uninsured in Dallas*

County. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project .To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a *4.* We believe this because, this project entails providing a basic PCP/PCMH setting for underserved patients who do not have one. This alone has a large impact on the individual in being able to meet basic healthcare needs and receive the medical attention they need. To determine the value to the community, we concluded that, on a scale of 1 – 5, the value of this project is a *4.* We believe this because, when a person is positively impacted, their dependence on community resources is better utilized and over time, will decrease. When these patients receive healthcare, they are able to manage their conditions better and in a timely manner, remain productive members of society, stay out of the ED and avoid costly clinical exacerbations.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121790303.1.1	***1.1.2***	***1.1.2 (A-C)***	***EXPAND EXISTING PRIMARY CARE CAPACITY-BAYLOR CLINIC CAPACITY EXPANSION***	
Baylor Medical Center at Garland				***121790303***
Related Category 3 Outcome Measure(s):	***121790303.3.1***	*3.IT-1.7*	*Controlling high blood pressure (Standalone measure)*	
	121790303.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores (Standalone)*	
	121790303.3.3	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores (Standalone)*	
	121790303.3.4	*3.IT-12.1*	*Breast Cancer Screening (Non-Standalone measure)*	
	121790303.3.5	*3.IT-12.5*	*Other USPSTF screening outcome (Influenza Vaccination) (Non-Standalone)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Establish additional/expand existing/relocate primary care clinics Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Baseline/Goal: Determine optimal usage of clinic space and shift utilization based on clinical need (i.e.: carve out space for consults and non-clinical issues to allow more space for providers to see a greater number of patients) Data Source: Documentation of space re-allocation/increased utilization plans Determine provider capacity to hold at least one evening clinic a week Milestone 1 Estimated Incentive Payment: $214,441 **Milestone 2** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers	**Milestone 3** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum **600** new, unduplicated patients will be seen at the Baylor Clinic over baseline Data Source: E.H.R Milestone 3 Estimated Incentive Payment: $233,944 **Milestone 4** [I-15]: Increase access to primary care capacity. Metric 1 [I-15.1]: Increase percentage of target population reached. Goal: Increase access to 15% of available Baylor Clinic capacity to eligible community patients (non-Baylor patients) Data Source: Electronic	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum **1150** new patients will be seen at the Baylor Clinic (cumulative over baseline) Data Source: E.H.R Milestone 5 Estimated Incentive Payment: $234,624 **Milestone 6** [I-15]: Increase access to primary care capacity. Metric 1 [I-15.1]: Increase percentage of target population reached. Goal: Increase access to 20% of available Baylor Clinic capacity to eligible community patients (non-Baylor patients) Data Source: Electronic Tracking/E.H.R	**Milestone 7** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.2]**:** Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum **1700** new patients will be seen at the Baylor Clinic (cumulative over baseline) Data Source: E.H.R Milestone 7 Estimated Incentive Payment: $193,820 **Milestone 8** [I-15]: Increase access to primary care capacity. Metric 1 [I-15.1]: Increase percentage of target population reached. Goal: Increase access to 25% of available Baylor Clinic capacity to eligible community patients (non-Baylor patients) Data Source: Electronic Tracking/E.H.R

121790303.1.1	***1.1.2***	***1.1.2 (A-C)***	***EXPAND EXISTING PRIMARY CARE CAPACITY-****BAYLOR CLINIC CAPACITY EXPANSION*	
Baylor Medical Center at Garland				***121790303***
Related Category 3 Outcome Measure(s):	***121790303.3.1***	*3.IT-1.7*	*Controlling high blood pressure (Standalone measure)*	
	121790303.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores (Standalone)*	
	121790303.3.3	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores (Standalone)*	
	121790303.3.4	*3.IT-12.1*	*Breast Cancer Screening (Non-Standalone measure)*	
	121790303.3.5	*3.IT-12.5*	*Other USPSTF screening outcome (Influenza Vaccination) (Non-Standalone)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: 1.0 new FTEs Data source: HR Documentation Milestone 2 Estimated Incentive Payment *(maximum amount):* $214,441	Tracking/E.H.R Milestone 4 Estimated Incentive Payment: $233,944		Milestone 6 Estimated Incentive Payment: $234,624	Milestone 8 Estimated Incentive Payment: $193,820
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $428,882	Year 3 Estimated Milestone Bundle Amount: $467,887		Year 4 Estimated Milestone Bundle Amount: $469,248	Year 5 Estimated Milestone Bundle Amount: $387,639
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,753,656				

Project Option 1.9.2 - Improve Access to Specialty Care-Expand Specialty Care Services

Unique Project ID: 121790303.1.2
Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Provider: Baylor Medical Center at Garland is a fully accredited, 240-bed medical center serving the residents of Garland, Texas, and the neighboring communities of Wylie, Rowlett, Sachse, Mesquite and Murphy. Recognized for comprehensive services in heart and vascular care, diagnostic and interventional imaging, women's services, neonatal intensive care, sleep medicine, digestive disease, family medicine, and physical medicine and rehabilitation, Baylor Garland has 582 physicians on its medical staff representing a wide range of specialties. Baylor Garland's service area represents a population of 640,000

Intervention(s): This project will increase access to needed specialty care services (i.e. outpatient visits with specialty physicians, hospital-based procedures) for uninsured patients under the care of a Baylor clinics in Garland. This is a new project, providing access to specialty care services previously unattainable for Medicaid/Uninsured patients.

Need for the project: Specialty services are a key element to providing a full continuum of care to patients (beyond what can be provided in a primary care clinic) and an important contributor to improved health outcomes and avoidance of costly clinical exacerbations. Shortage of specialty care was one of the key health needs identified in the RHP.

Target population: The target population will be a subset of established Baylor clinic patients who require specialty services. While historical data suggests 10-15% of all established patients will develop a need for specialty services, constraints in available specialists and facilities should allow the project to serve approximately 5% of all established patients within a given year. Between 90-95% of Baylor Clinic patients are Uninsured/Medicaid, we expect that patients served by this Specialty Care program will be at least 95% Uninsured/Medicaid.

Category 1 or 2 expected patient benefits: Over the course of DY2-DY5 an estimated 257 individual patients will be connected to specialty care services. This project will make the specialist part of the primary care team. Patients will receive better coordinated and timely care.

Category 3 outcomes: The Category 3 outcomes for this project were chosen because: 1) historical data from similar programs with specialists and 2) outcomes that have potential to show material improvement over a 2-3 year time period.

- IT-11.1: Improvement in Clinical Indicator in identified disparity group: Improvement in Asthma Bundle. Our goal is to improve performance of our Asthma metrics Percent of Opportunities Achieved (POA) from 73% completed opportunities currently to 76.9% (or 3.9% total improvement over baseline) completed opportunities in DY5.

- IT-12.2: Cervical Cancer Screening. Our goal is to increase the number of appropriate women receive screenings from 52.3% currently to 59.1% (or 6.8% total improvement over baseline) in DY5.

- IT-12.3: Colorectal Cancer Screening. Our goal is to increase the percentage of appropriate patients receive screenings from 33.5% currently to 40% (or 6.5% total improvement over baseline) in DY5.

Project Description

Patients (including Medicaid and Uninsured) who are seen at a Baylor Clinic and have an established PCMH there, can receive the following specialty care services: certain outpatient procedures such as: office visits with specialists, wound care, and facility based procedures such as cardiac catheterizations, certain surgeries (i.e.: gall bladder/hernia), excision of masses (breast, lymphoma), and cataract removal. This project excludes transplants, oncology and perinatal services. The specialty care referral and coordination would come from the PCMH clinic per request by the patient's PCP. Between 90-95% of Baylor Clinic patients are Uninsured/Medicaid, we expect that patients served by this Specialty Care program will be at least 95% Uninsured/Medicaid. Much of the value comes from building relationships, contracts and a network with local specialty care providers that can be easily accessible to this population. For Baylor Medical Center at Garland, one of the goals we have included in the project was to contract with providers in the community to create this specialty care network for the underserved population. Another facet of the project includes trying to make the specialist part of the primary care team. Through utilizing our electronic health record and specialty care referral coordinator, we hope engage specialists that provide procedures to also participate in the screening and educational needs of these patients. This is why we included Category 3 outcomes around Asthma improvement, Cervical and Colorectal cancer screening. We believe engaging specialists in these types of preventive services will help to integrate them into the primary care team. Sharing feedback through the electronic health record also will help to create a central repository of patient information and allow the care team to track and improve patient outcomes. Lastly, we expect value to come avoiding ED visits and more serious specialty care needs due to clinical exacerbations from not receiving timely and effective care.

Goals and Relationship to Regional Goals

The goals for this project are to 1) increase/improve access to specialty care services in the Garland area, 2) engage a greater number of providers/facilities to provide these services, 3) increase the number of completed specialty referrals for patients and 4) improve disease specific clinical outcomes affected by increased access to target specialists. As a result, we expect that more patients will have a better quality of life when they are given the appropriate specialty care, in a timely manner and in the appropriate venue. By managing the patient and coordinating the care through the Baylor Garland PCMH, we expect the patient will have fewer complications post procedure. According to the Community Health Needs Assessment, the demand for primary and specialty care services exceeds that of available physicians, thus limiting healthcare access for many low level management or specialized treatments for health

conditions[70]. This project would help to offset some of the demand for specialty care services and do so in a coordinated and meaningful way. The patients who need specialty care services, both inpatient and outpatient, would require a referral from their Baylor Clinic PCMH in order to receive the procedure and then also be able to follow-up with their PCP after the procedure/ test is completed. This synchronizes with the regional needs of providing access to more specialty care and also coordinates the care for the patient to ensure compliance timely care. As patients receive the specialty care they need, it is likely that clinical exacerbations of manageable conditions will decrease, lowering the cost of care in more expensive settings.

Challenges

The major challenges with providing increased access to specialty care are multiple: 1) lack of supply of specialty providers in the Region and even smaller supply who are willing to provide services to this population, 2) specialty care is expensive to provide for patients who have little or no ability to pay, 3) long wait lists to receive specialty care lead to clinical exacerbations and 4) no coordination or follow-up for patients who do receive specialty care leads to infections, healing issues and lack of wound management which can often lead to a hospital (re)admission. Through developing community relationships with providers and facilities in the area, we plan to find ways to provide more access points for these patients to receive the care they need, in a timely manner so that we are can monitor utilization and outcomes to be good stewards of the limited specialty care resources available in the Region.

5-year expected outcome for the performing provider and patients

The 5 year expected outcome is to provide specialty care to approximately 257 unduplicated patients through increasing the number of providers/facilities contracted to at least 9 in the Garland area. We also expect to increase the number of completed referrals for specialty care services 20% over baseline. Between 90-95% of Baylor Clinic patients are Uninsured/Medicaid, we expect that patients served by this Specialty Care program will be at least 95% Uninsured/Medicaid. Lastly, we expect to help facilitate the coordination and collaboration of specialists and primary care providers for our patients. We hope that by engaging specialists to do more complex procedures as well as preventive services that this will help create a more robust care team that will benefit the entire community.

Starting point/baseline

Currently, a small number of specialty referrals have been coordinated on a case-by-case basis with a limited network of specialty care providers and Baylor Medical Center at Garland. The baseline, therefore has not been closely tracked. A major focus of this project will be to more accurately capture baseline data and formalize the specialty care referral process. Historic data on specialty care demand amongst Baylor Clinic patients suggests that 10-15% of all patients develop a need for specialty care services at some point in their care. The constraints of limited specialty care providers and facilities willing to care for this population have allowed similar programs in the area to meet demand for approximately 5% of a clinic's patient population.

[70] RHP 9 Community Health Needs Assessment

Baylor Clinic patients are typically 90-95% Uninsured/Medicaid. We expect that about 95% of the patients we see in the Specialty Care program will be Uninsured/Medicaid patients.

Rationale

A key strategy for the Baylor Clinics has been the expansion of primary care access for the underserved population. Increased access to primary care has been strongly correlated with better health outcomes and lower avoidable hospital utilization within this patient population. While primary care providers are able to manage and treat many conditions, historic experience suggests that 10-15% of a clinic's patient population will likely develop a specialty care need at some point. Left untreated, this 10-15% of patients are likely to develop further exacerbation of health problems, experience more complications and increase the likelihood of avoidable hospital utilization. We chose this project to supplement our goals of engaging specialty care physicians in providing more advanced procedures/ screenings and also to conduct some basic preventive screenings and education for the patient. We feel that this will make specialists a formal part of the care team. Baylor Clinics have established relationships with providers in the community and as we grow, we will leverage those relationships in order to serve more of our patients. As Baylor Clinics take on more patients from the community, we anticipate that there will be an increased need for specialty care services in this population. This project proactively creates increased specialty access for these new patients as well established clinic patients who have historically had poor access to specialty care.

Project Components

We will complete all required project components for the expansion of specialty care project:

a) Increase service availability with extended hours: we will increase service availability by offering more appointments to patients in the outpatient setting and coordinate with surrounding hospitals to provide the inpatient services the patient may need

b) Increase number of specialty clinic locations: we plan to contract with at least 9 providers/facilities over the course of the waiver, providing more locations for patients to receive the specialty care they need

c) Implement transparent, standardized referral processes across the system: we already have a standard referral form and process which is documented in the EHR and is visible by staff but will work to improve tracking, reporting and collection of the referral data

d) Conduct quality improvement for project using methods such as rapid cycle improvement: we will engage in 1) identifying key challenges with the expansion of this project, 2) determine opportunities to scale all or part of the project- depending on available resources and financial constraints, 3) find ways to integrate the specialist into the care team as much as possible.

The selected milestones and metrics focus on improvement of coordinating the care for patients to receive specialty care and more of it. The Region has demonstrated a need to improve access to specialty care and fulfill some of the gaps that have been identified in the care that is unavailable. Our metrics and milestones are structured as such and the specialties identified will be a priority as the project progresses and more facilities/providers are contracted with to provide these services. The other metrics focus on increasing the number of appropriate referrals which entails identifying patients early on when certain minor procedures can be completed in lieu of the more expensive alternatives. Lastly, we have set specific metrics around the number of patients to be served in order to ensure that on top of referrals, actual patient lives are impacted and specialty care is delivered to these individuals.

Unique community needs identification number the project addresses

CN.3- Healthcare Capacity , CN.9- Specialty Care

How the project significantly enhances an existing delivery system reform initiative

This project does not receive any source of federal funding and has been identified as a significant Regional need. It enhances the existing delivery system reform initiative by coordinating specialty care through a primary care setting; thus managing utilization, costs and reducing complications for patients. This project would supply the specialty care needs identified by the Region and individual providers but also ensures that utilization is controlled.

Related Category 3 Outcome Measures

Based on our projected ability to contract with certain specialists available in the area, we have chosen outcome measures below that will be addressed upon establishing relationships with the specialties mentioned below.

Outcome Measure #1: IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (Standalone measure). We will measure improvement in Asthma for Baylor Clinic patients. Asthma affects about 19.6% of the Dallas County population and was identified as one of the top five conditions for cause of ED visits in the Region. Approximately 90.1% of these ED visits related to Asthma could have been handled in the outpatient setting. [71] At Baylor Health Care System, we have a standard set of Asthma metrics which consists of: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. We measure this yearly for our Asthma patients and calculate The Percent of Opportunity Achieved (POA). This is calculated by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population. POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of

[71] RHP 9 Community Health Needs Assessment

patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in asthma management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their asthma patients than in the prior reporting period. For an illustrative example: For Asthma- there are 4 opportunities (i.e. metrics) per patient (1) documentation of Action/Mgmt Plan, 2) Severity Assessment, 3) Controller Therapy for those who are eligible, and 4) Spirometry within last two years). The denominator would be # of patients x 4. So if there are 10 patients x 4 opportunities each = 40 opportunities to be achieved. If, in the course of the year, only 30 of those opportunities were completed, our POA (Percent of Opportunities Achieved) = 30/40=75%. To achieve a 10% improvement in POA, we would have to have completed at least 34/40 opportunities to get at 85% achievement.

Outcome Measure #2: IT-12.2 Cervical Cancer Screening (Non-Standalone Measure). In Dallas County, the incidence rate of cervical cancer is higher than the national average. In Dallas, the incidence rate of cervical cancer is 9.7 cases per 100,000 people[72]. According to the National Cancer Institute, African American women are more likely to be diagnosed with cervical cancer and Hispanic women have the highest cervical cancer incidence rate amongst all women[73]. There is opportunity to increase the screenings in the minority population through engaging OB/GYNs to provide screenings and education for this population. Additionally, these specialists can provide the advanced screenings/education not be available in a PCP/PCMH setting.

Outcome Measure #3: IT-12.3 Colorectal cancer screening (Non-Standalone Measure). In Dallas County the incidence rate of colorectal cancer is 43.3 cases per 100,000. Only 60% of the population in Dallas County has regular colon screenings. It is the second leading cause of cancer related deaths in the US and as many as 60% of the deaths from colorectal cancer could be avoided with regular screening tests.[74] According to the Centers for Disease Control and Prevention, Hispanics and African Americans are less likely to get screened for colorectal cancer and it is often found in the latter stages of the disease as compared to their Caucasian counterparts[75]. There is an opportunity to increase the colorectal cancer screening rates by engaging specialists in the Dallas County area to provide these basic and advanced screenings along with education that is focused on this particular topic.

Relationship to other Projects

121790303.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
Increasing access to specialty care is related to the project of expanding primary care capacity for two reasons: 1) as more patients enter the PCMH, there will be an increase in the need for specialty care services and 2) primary care is essential to coordinate the specialty care and to

[72] Healthy People North Texas: http://www.healthyntexas.org
[7] National Cancer Institute: http://www.cancer.gov/
[74] Healthy People North Texas: http://www.healthyntexas.org
[75] Centers for Disease Control and Prevention: http://www.cdc.gov/

allow for adequate follow-up for the patient, in order to avoid any complications or issues that may arise after the specialty care is received

Related Category 4 Population-focused improvements

While complications and failures that occur in the hospital cannot be avoided through just providing specialty care, many of the post-operative and minor procedures can be handled in the outpatient setting. Some of the inpatient specialty care proposed to be provided under this project would directly be tied to some of the Category 4 metrics.
RD-1.1, RD-1.4,RD-2.1, RD-2.4, RD-2.5, RD.2.7,RD-3.1, RD-3.3, RD-3.4, RD-3.5, RD-3.7, RD-3.8, RD-3.10, RD-3.11, RD-3.13, RD-3.14, RD-3.15, RD-3.16, RD-3.20, RD-3.21, RD-3.22, RD-3.27, RD-3.37, RD-3.38, RD-3.40, RD-3.41, RD-3.44, RD-3.45, RD-3.36, RD-3.48, RD-3.51, RD-3.52, RD-3.53,RD-4.1, RD-4.2

Relationship to Other Projects

In addition to Baylor Medical Center at Garland, projects to expand specialty care include:

- Baylor Medical Center at Carrollton (Trinity): 195018001.1.2
- Baylor Medical Center at Irving: 121776204.1.2
- Baylor University Medical Center: 139485012.1.2

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

- Parkland Health & Hospital Center – 127295703.1.5
- UT Southwestern – Faculty Practice Plan – 126686802.1.5

Our project does not serve the same specialty care population as the aforementioned projects.

Plan for Learning Collaborative.
We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. *Baylor Medical Center at Garland* has computed the value of this project using the model developed at

the Regional level. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor Medical Center at Garland defined the population that will be directly impacted by the project as underserved individuals in the Garland and Dallas County area that need access to specialty care services. People who receive these services must be a patient of the Baylor Clinic prior to being referred to specialty care. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3. We believe this to be the correct number because, patients will receive the procedures, diagnostics, etc. that they previously were unable to afford or could not have access to. To determine the value to the community, we concluded that, on a scale of 1 – 5, the value of this project is a *3* .We believe this to be the correct number because, fewer clinical exacerbations lead to less frequency of costly procedures and surgeries versus waiting for specialty care and having a more serious condition occur.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121790303.1.2	***1.9.2***	***1.9.2 (A-D)***	***IMPROVE ACCESS TO SPECIALTY CARE*-EXPAND SPECIALTY CARE SERVICES**	
Baylor Medical Center at Garland				*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.6*	*3.IT-11.1*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider – Asthma Improvement (Standalone measure)*	
	121790303.3.7	*3.IT-12.2*	*-Cervical Cancer Screening (Non-Standalone Measure)*	
	121790303.3.8	*3.IT-12.3*	*-Colorectal cancer screening (Non-Standalone Measure)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct specialty care gap assessment based on community need Metric 1 [P-1.1]: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline/Goal: Documentation of gap assessment based on Baylor Clinic patient need and how this coincides with Regional needs Data Source: E.H.R Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 189,934 **Milestone 2** [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: Determine current wait time for specialty care services by specialty Data Source: E.H.R (chart review) Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 189,934	**Milestone 3** [P-5]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment Metric 1 [P-5.1]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians. Baseline/Goal: Determine average referral time for patients that were seen in DY3. This metric is the subsequent step to **P-3.1**. Data Source: E.H.R Milestone 3 Estimated Incentive Payment: $ 138,138 **Milestone 4** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 3	**Milestone 6** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 6 providers or facilities to provide specialty care services (over DY2) Data Source: Documentation of implemented contracts Milestone 6 Estimated Incentive Payment: $ 207,810 **Milestone 7** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Provide at least 169	**Milestone 8** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 9 providers or facilities to provide specialty care services (over DY2) Data Source: Documentation of implemented contracts Milestone 8 Estimated Incentive Payment: $ 171,669 **Milestone 9** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Provide at least **257**

121790303.1.2	***1.9.2***	***1.9.2 (A-D)***	***IMPROVE ACCESS TO SPECIALTY CARE*-EXPAND SPECIALTY CARE SERVICES**	
Baylor Medical Center at Garland				*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.6* *121790303.3.7* *121790303.3.8*	*3.IT-11.1* *3.IT-12.2* *3.IT-12.3*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider – Asthma Improvement (Standalone measure)* *-Cervical Cancer Screening (Non-Standalone Measure)* *-Colorectal cancer screening (Non-Standalone Measure)*		
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		providers or facilities to provide specialty care services (over DY2) Data Source: Documentation of implemented contracts Milestone 4 Estimated Incentive Payment: $ 138,138 **Milestone 5** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Provide at least **83** unduplicated patients with specialty care services over DY2 Data Source: E.H.R Milestone 5 Estimated Incentive Payment: $ 138,138	unduplicated patients with specialty care services over DY2 Data Source: E.H.R Milestone 7 Estimated Incentive Payment: $207,810	unduplicated patients with specialty care services over DY2 Data Source: E.H.R Milestone 9 Estimated Incentive Payment: $ 171,669
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 379,867		Year 3 Estimated Milestone Bundle Amount: $ 414,415	Year 4 Estimated Milestone Bundle Amount: $ 415,619	Year 5 Estimated Milestone Bundle Amount: $ 343,338

121790303.1.2	***1.9.2***	***1.9.2 (A-D)***	***IMPROVE ACCESS TO SPECIALTY CARE-***EXPAND SPECIALTY CARE SERVICES	
Baylor Medical Center at Garland				*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.6*	*3.IT-11.1*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider – Asthma Improvement (Standalone measure)*	
	121790303.3.7	*3.IT-12.2*	*-Cervical Cancer Screening (Non-Standalone Measure)*	
	121790303.3.8	*3.IT-12.3*	*-Colorectal cancer screening (Non-Standalone Measure)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 1,553,239				

Project Option 1.1.2 - Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

Unique Project ID: 121776204.1.1
Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Provider: Baylor Irving serves Irving, Las Colinas and the surrounding communities. The not-for-profit 296-bed hospital offers advanced treatment capabilities in cardiology, orthopedics, oncology, digestive disorders, diagnostic imaging, physical medicine and emergency care. Baylor Irving's service area represents a population of 546,000.

Intervention(s): This project will implement increased access to two Patient-Centered Medical Home (PCMH) clinics designed to provide comprehensive and high-quality primary care services to underserved patients in the Baylor Medical Center at Irving service area. The project is an expansion of Baylor's Clinic strategy in Irving and Dallas County. Historically, Baylor's Community Care clinics have provided access to patients following discharge from Baylor Medical Center at Irving. This expansion will focus on the recruitment of more underserved (Medicaid/Uninsured) patients from the community at-large and patients awaiting access to other public resources.

Need for the project: Access to quality primary care services has been demonstrated to improve health outcomes and reduce avoidable hospital utilization among underserved patient populations.This project will increase access to a PCMH for more patients in the community.

Target population: The 872,000 uninsured and Medicaid population in Dallas County without a PCP/PCMH. Clinic capacity will allow approximately 600 new patients/year to receive services. We expect that 90-95% of the new patients/year will be uninsured/Medicaid patients.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide access to an anticipated 1,800 new patients from the Irving community.

Category 3 outcomes: Category 3 outcomes for this project were chosen because: 1) the ambulatory setting of the project and 2) historical trends of metrics that had material impact on patients in a 2-3 year time period. All baselines will be reevaluated and reestablished in DY2

- IT-1.7: Controlling High Blood Pressure. Our goal is to increase the number of patients with controlled blood pressure (< 140/80 mmHg) from 71.4% currently to 75.5% in DY5 (or a total of 4.1% improvement over baseline).

- IT-6.1: Percent Improvement over baseline of patient satisfaction scores (clinic wait times). Our goal is to increase patient satisfaction from 82.3% currently to 84.8% in DY5 (or a total of 2.5% improvement over baseline).

- IT-6.1: Percent Improvement over baseline of patient satisfaction scores (timely response to patient phone calls). Our goal is to increase patient satisfaction from 88.0% currently to 89.7% in DY5 (or a total of 1.7% improvement over baseline).

- IT-12.1: Breast Cancer Screening. Our goal is to increase the number of appropriate women who receive breast cancer screenings from 42.5% currently to 50.7% in DY5 (or a total of 8.2% improvement over baseline)

- IT-12.5: Other USPSTF screening outcome (Influenza Vaccination). Our goal is to increase the number of adults 18 and over who receive an influenza vaccination from 60.3% currently to 66.0% in DY5 (or a total of 5.7% improvement over baseline).

Project Description

The Baylor Clinic on the Baylor Medical Center at Irving campus, would expand their current capacity by opening their patient panels to non-Baylor patients (including Medicaid and Uninsured) and fully utilize the space and providers' capacity. Additional support staff will be hired to better coordinate patient care, ensure transition from the hospital to a Baylor Clinic and help to facilitate the care of the complex underserved patients. The Baylor Clinic on the Baylor Medical Center at Irving is already an NCQA recognized PCMH, thus the focus of this project would be to open the current panel to the underserved community and provide volume relief for other providers/ health systems in the area. We expect that approximately 90-95% of new patients will be Medicaid/Uninsured. Additionally, the clinic would provide these high quality primary care services to a greater number of people. Essentially, through expanding the capacity of the current clinic, adding additional support staff and services, a patient can receive comprehensive and complete services in one primary care location. In addition to receiving primary care, this project also proposes that ancillary services such as labs, imaging (i.e. CT scans, MRI, ultrasound, etc.) and diagnostics (i.e. colonoscopy, stress tests, etc.) would also be provided upon physician request. This project aims to close the loop of care and increase patient compliance by co-locating/coordinating many of the essential services that the underserved population often has issues accessing and completing.

Goals and Relationship to Regional Goals

The 5 year goals of this project are: (1) to provide a PCMH and PCP to a greater number of the Irving area underserved population, (2) provide continuity and transition to post-acute care services, (3) improve patients' health outcomes and status (4) create an integrated primary care model for underserved patients in Dallas County (Irving) to receive high quality, complete care keeping these patients from utilizing the emergency department for low acuity needs and preventing re(admissions) that could have been avoided with proper primary care. The Region has a primary care provider and capacity issue for the underserved population. This project aims to increase primary care access and provide high quality, comprehensive care to patients in a less costly setting. By providing more patients with the primary care they need, they will not use the ED as a means to receive basic care.

Challenges

Providers and hospitals are reluctant to expand primary care capacity in charity clinics due to the inherent necessity for other downstream services, procedures, and costs associated with adding a patient with multiple, complex needs from the underserved population. Basic primary care needs are unable to be fulfilled because of the lack of funding and capacity to take more patients, thus leading to increased (re)admissions and prevalence of disease complications. Lastly, due to the transient nature of this population, it is difficult to achieve the full extent of quality and clinical outcomes associated with a Patient Centered Medical Home. This project addresses these challenges by creating a low-cost, effective, co-located and comprehensive model specifically for the underserved population.

5-year expected outcome for the performing provider and patients

At the end of 5-years, 1850 new, unduplicated patients will have received PCMH/primary care services at the Baylor Clinics on the Baylor Medical Center at Irving Campus. We expect that at least 15% of patients who continue to come to the Baylor Clinics will achieve better Adult Preventive Scores (APS) and have overall better clinical outcomes.

Starting point/baseline

From July 2010 to June 2011 the Baylor Clinics on the Baylor Medical Center at Irving served over 650 unduplicated patients. To date, there has not been a formal process to take patients from the community; capacity is typically reserved for those patients that come from a Baylor Medical Center at Irving ED. In addition to patients discharged from Baylor Medical Center at Irving, our target population will focus on 1850 of the 872,000+ patients that are uninsured in Dallas County[76] and 36.1% uninsured in the Dallas-Plano-Irving area.[77] We plan on recruiting patients into our Baylor Clinics through a combination of utilizing our inpatient care navigation services and furthering relationships with community partners. Currently, we have Care Navigators which proactively identify potential hospital patients that would be candidates to be seen in a Baylor Clinic. Also, through the creation of project 121776204.2.3 (navigation services for high risk patients), will provide additional patients to be seen at the Baylor Clinic. Lastly, our relationship with other providers and community partners will also serve as a referral source into the clinic.

Rationale

We chose this project option because of the demonstrated need in the RHP and to leverage our PCP/PCMH model to patients outside of the Baylor system. According to the Community Health Needs Assessment, 100% of the counties in the region are designated as medically underserved areas and 36.1% of individuals in Dallas County are uninsured[78]. The combination of these two factors leads to increased ED utilization and clinical complications due to lack of adequate

[76] http://quickfacts.census.gov/qfd/states/48/48439.html
[77] Healthy North Texas: http://www.healthyntexas.org
[78] RHP 9 Community Health Needs Assessment

access to coordinated, primary care services. According to the Dallas Fort Worth Hospital Council database, 68% of ED visits related to the top conditions in the county was non-emergent/primary care treatable. The top five conditions from the ED that resulted in an inpatient admission were: stroke, diabetes, congestive heart failure, weak/failing kidneys, chronic bronchitis and heart attack. These services can be better managed in a primary care setting, ensuring 1) the patient receives needed care, 2) adequate follow-up is provided after services are accessed and 3) services are provided in a timely fashion so that long term disease complication are avoided. Baylor Clinics have a proven track record for improving patient outcomes and creating primary care capacity in underserved areas. By leveraging this model and expertise through expanding these services to beyond Baylor patients would be a service to the community and improve health outcomes for patients and other performing providers. This project is a low-cost, high-quality solution to a pressing need in the community.

Project Components

a) *Expand primary care clinic space:* We will not be physically expanding the primary care clinic space, but we will be more fully utilizing the current space we have and will take advantage of underutilized space in the Baylor Clinic to see more patients. By carving out space to handle non-clinical needs such as finding community resources, education, coordinating care/appointments, etc., this will allow more room for providers to see patients and handle clinical needs.

b) *Expand primary care clinic hours:* We plan to expand our hours through the expansion of care teams. By adding (or modifying current roles of) mid-levels and other non-physician support staff, there will be more provider hours available, more appointment availability through expanding our current capacity from two appointment slots an hour to four (for example).

c) *Expand primary care clinic staffing*. We plan on hiring at least 2 FTEs to add to the care team in Irving in order to increase our capacity and services offered. We also plan to make the current staff hours more efficient so that more appointments per hour can be offered to patients.

The Baylor Clinics at Baylor Medical Center at Irving are NCQA recognized[79], thus the focus of the metrics is on further improving and refining the PCMH baseline that has been established. Improvement metrics that hone in on increasing capacity, patient satisfaction and serving more patients are the impetus of this project. We also plan on engaging in continuous quality improvement activities on a regular basis that focus on: 1) identifying key challenges with the expansion of this project, 2) determine opportunities to scale all or part of the project-depending on available resources and financial constraints and 3) look for ways to increase efficiency and effectiveness.

Unique community needs identification number the project addresses

CN.3- Healthcare Capacity, CN.12-ED Usage and Readmissions

[79] NCQA: http://www.ncqa.org

Describe how the project significantly enhances an existing delivery system reform initiative
This project has not received any funding from any federal source. It enhances current delivery system reform initiative by focusing on providing high quality, low cost and comprehensive services to the underserved population. It encourages decreased utilization of unnecessary specialty care, ED utilization and promotes better preventive services to avoid downstream complications and costs. It exemplifies the Triple Aim from the Institute of Healthcare Improvement's three components of better care, better health and lower cost.

Related Category 3 Outcome Measures
Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients got a PCMH at a Baylor Clinic.

Outcome Measure #1: IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone measure). Controlling high blood pressure is essential in avoiding heart attacks, stroke, heart failure and a multitude of other diseases and complications. Through medication management, proper primary care attention and education, patients can achieve better blood pressure control in the outpatient setting. In Region 9, Hypertension was identified as one of the top 5 most prevalent diseases in the area for ED admissions[80]. A recent article in the New York Times suggested that hypertensive complications can be especially deadly in the African American population,[81] who make up 22.5% of the RHP 9 population[82] and 12.3% of the Irving population.[83] Patients who are uncontrolled will receive the attention they need to get their hypertension under control. Patients will receive medication management, lifestyle management techniques and education about their illness in this clinic PCMH setting.

Outcome Measure #2, #3: IT-6.1 Percent Improvement over baseline of patient satisfaction scores (Standalone measure). Outcome Measure #2 will measure: *Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Clinic Wait Times.* Outcome Measure #3 will measure: *Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Response Time to Patient Phone Calls.* Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Data from Press Ganey Associates in 2007[84] has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less physician/staff time, reducing length of

[80] RHP 9 Community Health Needs Assessment
[81] http://health.nytimes.com/health/guides/disease/hypertension/complications.html
[82] RHP 9 Community Health Needs Assessment
[83] Census Quick Track: http://quickfacts.census.gov/qfd/states/48/4829000.html
[84] Drain, M., Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

visits and wait times for the overall practice. Baylor Clinics have shown high performance in all measures related to patient satisfaction, however there is opportunity for improvement.

The following two outcome measures focus on adult preventive services. Adult Preventive services as recommended by USPSTF are low cost, highly effective interventions that prevent and maintain patients' health status.

Outcome Measure #4: IT-12.1 Breast Cancer Screening (Non-Standalone Measure). In Dallas County, 23.7/100,000 women die from breast cancer with the rate in African American at 37/100,000. This statistic is considered to be higher than the national average. There is room for improvement with this metric to screen more women and utilize early detection methods for breast cancer.[85]

Outcome Measure #5: IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate). In Dallas County, only 65% of individuals over the age of 18 received an influenza vaccination in the past 12 months.[86] The rate of influenza vaccinations in the Region is quite low and there is an opportunity to increase the number in the target population that receive this basic vaccination in order to prevent exacerbations of health issues, reduce the prevalence of influenza and prevent ED visits related to influenza that can otherwise be handled in an outpatient setting.

Relationship to other Projects

121776204.2.1 Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program: The Chronic Care Management project is related because the services will be co-located and integrated to ensure that high risk patients with chronic disease would be identified, addressed and managed.

PASS2 - 121776204.2.4 Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs - Vulnerable Patient Network (Home Visit Program)

121776204.1.2- Improve Access to Specialty Care-Expand Specialty Care Services Improving access to specialty care is related to this project because there are services that patients need that are not available in the Baylor Clinics. Patients would receive coordinated care/referrals to these services as well as the necessary follow-up required for continuity of care in a primary care clinic setting.

121776204.2.2- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment

The project involving developing care management functions to integrate primary and behavioral health needs of individuals is related to this project of expansion of primary capacity because behavioral health will now be a co-located services and a standard part of patient care.

[85] Healthy North Texas: www.healthyntexas.org

[86] RHP 9 Community Health Needs Assessment

Related Category 4 Population-focused improvements

This project will help to support, reinforce and enable Category 4 population focused improvements through project design and appropriate intervention for targeted populations: RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.7, RD-1.8; RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD 2.7; RD-3.1, RD-3.5, RD-3.6, RD-3.10, RD-3.11, RD-3.22, RD-3.26, RD-3.36; RD-4.1, RD-4.2

Relationship to other Performing Providers' Projects and the Plan for Learning Collaborative

Performing Provider	Unique Project ID
Baylor Medical Center at Garland	121790303.1.1
Baylor Medical Center at Carrollton (Trinity)	195018001.1.1
Baylor University Medical Center	139485012.1.1
Children's Medical Center	138910807.1.1
Children's Medical Center	138910807.1.2
Medical City Dallas (HCA)	020943901.1.3
Parkland Health & Hospital System	127295703.1.1
Parkland Health & Hospital System	127295703.1.2
Parkland Health & Hospital System	127295703.1.6
Parkland Health & Hospital System	127295703.1.1
Texas Health Presbyterian – Dallas	020908201.1.1
UT Southwestern Medical Center Faculty Plan	126686802.1.1
UT Southwestern Medical Center Faculty Plan	126686802.1.2

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. *Baylor Medical Center at Irving* has computed the value of this project using the model developed at the Regional level.

Baylor Medical Center at Irving defined the population that will be directly impacted by the project as *1850 underserved patients in the Dallas area of the 872,000+ uninsured in Dallas County.* We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.To

determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a *4.* We believe, this because the project entails providing a basic PCP/PCMH setting for underserved patients who do not have one. This alone has a large impact on the individual in being able to meet basic healthcare needs and receive the medical attention they need to sustain their health. To determine the value to the community, we concluded that, on a scale of 1 – 5, the value of this project is a *4.* We believe this to be the correct number because, when these patients receive healthcare, they are able to manage their conditions better and in a timely manner, remain productive members of society, stay out of the ED and avoid costly clinical exacerbations.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121776204.1.1	***1.1.2***	***1.1.2 (A-C)***	***EXPAND EXISTING PRIMARY CARE CAPACITY-BAYLOR CLINIC CAPACITY EXPANSION***	
	Baylor Medical Center at Irving			***121776204***
Related Category 3 Outcome Measure(s):	*121776204.3.1* *121776204.3.2* *121776204.3.3* *121776204.3.4* *121776204.3.5*	*3.IT-1.7* *3.IT-6.1* *3.IT-6.1* *3.IT-12.1* *3.IT-12.5*	*Controlling high blood pressure (Standalone measure)* *Percent improvement over baseline of patient satisfaction scores (Standalone)* *Percent improvement over baseline of patient satisfaction scores (Standalone)* *Breast Cancer Screening (Non-Standalone measure)* *Other USPSTF screening outcome (Influenza Vaccination) (Non-Standalone)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Establish additional/expand existing/relocate primary care clinics Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Baseline/Goal: Determine optimal usage of clinic space and shift utilization based on clinical need (i.e.: carve out space for consults and non-clinical issues to allow more space for providers to see a greater number of patients) Data Source: Documentation of space re-allocation/increased utilization plans Determine provider capacity to hold at least one evening clinic a week Milestone 1 Estimated Incentive Payment: $183,110 **Milestone 2** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for	**Milestone 3** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum **650** new, unduplicated patients will be seen at the Baylor Clinic over baseline Data Source: E.H.R Milestone 3 Estimated Incentive Payment: $199,763 **Milestone 4** [I-15]: Increase access to primary care capacity. Metric 1 [I-15.1]: Increase percentage of target population reached. Goal: Increase access to 15% of available Baylor Clinic capacity to eligible community patients (non-Baylor patients) Data Source: Electronic		**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum **1250** new patients will be seen at the Baylor Clinic (cumulative over baseline) Data Source: E.H.R Milestone 5 Estimated Incentive Payment: $200,343 **Milestone 6** [I-15]: Increase access to primary care capacity. Metric 1 [I-15.1]: Increase percentage of target population reached. Goal: Increase access to 20% of available Baylor Clinic capacity to eligible community patients (non-Baylor patients) Data Source: Electronic	**Milestone 7** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.2**]:** Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum **1850** new patients will be seen at the Baylor Clinic (cumulative over baseline) Data Source: E.H.R Milestone 7 Estimated Incentive Payment: $165,501 **Milestone 8** [I-15]: Increase access to primary care capacity. Metric 1 [I-15.1]: Increase percentage of target population reached. Goal: Increase access to 25% of available Baylor Clinic capacity to eligible community patients (non-Baylor patients) Data Source: Electronic Tracking/E.H.R

121776204.1.1	***1.1.2***	***1.1.2 (A-C)***	***EXPAND EXISTING PRIMARY CARE CAPACITY-****BAYLOR CLINIC CAPACITY EXPANSION*	
Baylor Medical Center at Irving				***121776204***
Related Category 3 Outcome Measure(s):	*121776204.3.1* *121776204.3.2* *121776204.3.3* *121776204.3.4* *121776204.3.5*	*3.IT-1.7* *3.IT-6.1* *3.IT-6.1* *3.IT-12.1* *3.IT-12.5*	*Controlling high blood pressure (Standalone measure)* *Percent improvement over baseline of patient satisfaction scores (Standalone)* *Percent improvement over baseline of patient satisfaction scores (Standalone)* *Breast Cancer Screening (Non-Standalone measure)* *Other USPSTF screening outcome (Influenza Vaccination) (Non-Standalone)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
existing providers Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: 0.5 new FTEs Data source: Documentation of hired employees Milestone 2 Estimated Incentive Payment *(maximum amount):* $183,110	Tracking/E.H.R Milestone 4 Estimated Incentive Payment: $199,763		Tracking/E.H.R Milestone 6 Estimated Incentive Payment: $200,343	Milestone 8 Estimated Incentive Payment: $165,501
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $366,219	Year 3 Estimated Milestone Bundle Amount: $399,525		Year 4 Estimated Milestone Bundle Amount: $400,686	Year 5 Estimated Milestone Bundle Amount: $331,002
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,497,432				

Project Option 1.9.2 - Improve Access to Specialty Care-Expand Specialty Care Services

Unique Project ID: 121776204.1.2
Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Provider: Located in the heart of the Dallas-Fort Worth Metroplex, Baylor Irving serves Irving, Las Colinas and the surrounding communities. The not-for-profit 296-bed hospital offers advanced treatment capabilities in cardiology, orthopedics, oncology, digestive disorders, diagnostic imaging, physical medicine and emergency care. Baylor Irving's service area represents a population of 546,000.

Intervention(s): This project will increase access to needed specialty care services (i.e. outpatient visits with specialty physicians, hospital-based procedures) for uninsured patients under the care of a Baylor clinics in Irving. This is a new project and will provide access to specialty services previously unattainable for Medicaid/Uninsured patients

Need for the project: Specialty services are a key element to providing a full continuum of care to patients (beyond what can be provided in a primary care clinic) and an important contributor to improved health outcomes and avoidance of costly clinical exacerbations. Shortage of specialty care was one of the key health needs identified in the RHP.

Target population: The target population will be a subset of established Baylor clinic patients who require specialty services. While historical data suggests 10-15% of all established patients will develop a need for specialty services, constraints in available specialists and facilities should allow the project to serve approximately 5% of all established patients within a given year. Baylor Clinic patients are typically 90-95% Uninsured/Medicaid. We expect that about 95% of the patients we see in the Specialty Care program will be Uninsured/Medicaid patients.

Category 1 or 2 expected patient benefits: Over the course of DY2-DY5 an estimated 261 individual patients will be connected to specialty care services. This project will make the specialist part of the primary care team. Patients will receive better coordinated and timely care.

Category 3 outcomes: The Category 3 outcomes for this project were chosen because: 1) historical data from similar programs with specialists and 2) outcomes that have potential to show material improvement over a 2-3 year time period. All baselines will be reevaluated and reestablished in DY2

- IT-11.1: Improvement in Clinical Indicator in identified disparity group: Improvement in Asthma Bundle. Our goal is to improve performance of our Asthma metrics Percent of Opportunities Achieved (POA) from 18.8% completed opportunities currently to 30.4% (or 11.2% total improvement over baseline) completed opportunities in DY5.

- IT-12.2: Cervical Cancer Screening. Our goal is to increase the number of appropriate women receive screenings from 72.2% currently to 76.2% (or 4% total improvement over baseline) in DY5.

- IT-12.3: Colorectal Cancer Screening. Our goal is to increase the percentage of appropriate patients receive screenings from 39.7% currently to 48.3% (or 8.6% total improvement over baseline) in DY5.

Project Description

Patients (including Medicaid and Uninsured) who are seen at a Baylor Clinic and have an established PCMH there, can receive the following specialty care services: certain outpatient procedures such as: office visits with specialists, wound care, and facility based procedures such as cardiac catheterizations, certain surgeries (i.e.: gall bladder/hernia), excision of masses (breast, lymphoma), and cataract removal. This project excludes transplants, oncology and perinatal services. The specialty care referral and coordination would come from the PCMH clinic per request by the patient's PCP. Baylor Clinic patients are typically 90-95% Uninsured/Medicaid. We expect that about 95% of the patients we see in the Specialty Care program will be Uninsured/Medicaid patients. Much of the value comes from building relationships, contracts and a network with local specialty care providers that can be easily accessible to this population. For Baylor Medical Center at Irving, one of the goals we have included in the project was to contract with providers in the community to create this specialty care network for the underserved population. Another facet of the project includes trying to make the specialist part of the primary care team. Through utilizing our electronic health record and specialty care referral coordinator, we hope engage specialists that provide procedures to also participate in the screening and educational needs of these patients. This is why we included Category 3 outcomes around Asthma improvement, Cervical and Colorectal cancer screening. We believe engaging specialists in these types of preventive services will help to integrate them into the primary care team. Sharing feedback through the electronic health record also will help to create a central repository of patient information and allow the care team to track and improve patient outcomes. Lastly, we expect value to come avoiding ED visits and more serious specialty care needs due to clinical exacerbations from not receiving timely and effective care.

Goals and Relationship to Regional Goals

The goals for this project are to 1) increase/improve access to specialty care services in the Irving area, 2) engage a greater number of providers/facilities to provide these services, 3) increase the number of completed specialty referrals for patients and 4) improve disease specific clinical outcomes affected by increased access to target specialists. As a result, we expect that more patients will have a better quality of life when they are given the appropriate specialty care, in a timely manner and in the appropriate venue. By managing the patient and coordinating the care through the Baylor Irving PCMH, we expect the patient will have fewer complications post procedure. According to the Community Health Needs Assessment, the

demand for primary and specialty care services exceeds that of available physicians, thus limiting healthcare access for many low level management or specialized treatments for health conditions[87]. This project would help to offset some of the demand for specialty care services and do so in a coordinated and meaningful way. The patients who need specialty care services, both inpatient and outpatient, would require a referral from their Baylor Clinic PCMH in order to receive the procedure and then also be able to follow-up with their PCP after the procedure/test is completed. This synchronizes with the regional needs of providing access to more specialty care and also coordinates the care for the patient to ensure compliance timely care. As patients receive the specialty care they need, it is likely that clinical exacerbations of manageable conditions will decrease, lowering the cost of care in more expensive settings.

Challenges

The major challenges with providing increased access to specialty care are multiple: 1) lack of supply of specialty providers in the Region and even smaller supply who are willing to provide specialty care services to this population, 2) specialty care is expensive to provide for patients who have little or no ability to pay, 3) long wait lists to receive specialty care lead to clinical exacerbations due to less timely care and 4) no coordination or follow-up for patients who do receive specialty care leading to infections, healing issues and lack of wound management which can often lead to a hospital (re)admission. Through developing community relationships with providers and facilities in the area, we plan to find ways to provide more access points in a timely manner so that we are can monitor utilization and outcomes to be good stewards of the limited specialty care resources available in the Region.

5-year expected outcome for the performing provider and patients

The 5 year expected outcome of increasing access to specialty care is to provide specialty care to approximately 261 unduplicated patients over the waiver period through increasing the number of providers/facilities contracted to at least 9 in the Irving area. We also expect to increase the number of completed referrals for specialty care services by 20% over baseline. Lastly, we expect to help facilitate the coordination and collaboration of specialists and primary care providers for our patients. We hope that by engaging specialists to do more complex procedures as well as preventive services that this will help create a more robust care team that will benefit the entire community.

Starting point/baseline

Currently, a small number of specialty referrals have been coordinated on a case-by-case basis with a limited network of specialty care providers and Baylor Medical Center at Irving. The baseline, therefore has not been closely tracked. A major focus of this project will be to more accurately capture baseline data and formalize the specialty care referral process. Historic data on specialty care demand amongst Baylor Clinic patients suggests that 10-15% of all patients develop a need for specialty care services at some point in their care. The constraints of limited specialty care providers and facilities willing to care for this population have allowed similar programs in the area to meet demand for approximately 5% of a clinic's patient population.

[87] RHP 9 Community Health Needs Assessment

Baylor Clinic patients are typically 90-95% Uninsured/Medicaid. We expect that about 95% of the patients we see in the Specialty Care program will be Uninsured/Medicaid patients.

Rationale

A key strategy for the Baylor Clinics has been the expansion of primary care access for the underserved population. Increased access to primary care has been strongly correlated with better health outcomes and lower avoidable hospital utilization within this patient population. While primary care providers are able to manage and treat many conditions, historic experience suggests that 10-15% of a clinic's patient population will likely develop a specialty care need at some point. Left untreated, this 10-15% of patients is likely to develop further exacerbation of health problems, experience more complications and increase the likelihood of avoidable hospital utilization. We chose this project option to supplement our goals of engaging specialty care physicians in providing the more complex and advanced procedures/screenings but also to conduct some basic preventive screenings and education for the patient. We feel that this will make specialists a formal part of the overall care team. Baylor Clinics have established relationships with providers in the community and as we grow, we plan to leverage and expand those relationships in order to serve more of our patients. As Baylor Clinics take on more patients from the community, we anticipate that there will be an increased need for specialty care services in this population. This project proactively creates increased specialty access for these new patients as well established clinic patients who have historically had poor access to specialty care.

Project Components

We plan on completing all required project components for the expansion of specialty care:

a) Increase service availability with extended hours: we will increase service availability by offering more appointments to patients in the outpatient setting and coordinate with surrounding hospitals to provide the inpatient services the patient may need

b) Increase number of specialty clinic locations: we plan to contract with at least 9 providers/facilities over the course of the waiver, providing more locations for patients to receive the specialty care they need

c) Implement transparent, standardized referral processes across system: we have a standard referral form and process, documented in the patient EHR and visible to staff and will work to improve tracking, reporting and collection of referral data

d) Conduct quality improvement for project using methods such as rapid cycle improvement: we will engage in 1) identifying key challenges with the expansion of this project, 2) determine opportunities to scale all or part of the project- depending on

available resources and financial constraints, 3) find ways to integrate the specialist into the care team as much as possible.

The chosen milestones and metrics focus on coordinating care for patients to receive specialty care and more of it. The Region has demonstrated a need to improve access to specialty care and fill some of the identified care gaps. Our metrics and milestones are structured as such and the specialties identified will be a priority as the project progresses and more facilities/providers are contracted with to provide these services. The other metrics focus on increasing the number of appropriate referrals which entails identifying patients early on when certain minor procedures can be completed in lieu of the more expensive alternatives. Lastly, we have set specific metrics around the number of patients that will be served in order to ensure that on top of referrals, actual patient lives are impacted and specialty care is delivered.

Unique community need identification number the project addresses

CN.3- Healthcare Capacity, CN.9- Specialty Care

Describe how the project significantly enhances an existing delivery system reform initiative

This project does not receive any source of federal funding and has been identified as a significant Regional need. It enhances the existing delivery system reform initiative by coordinating specialty care through a primary care setting; thus managing utilization, costs and reducing complications for patients. This project would supply the specialty care needs identified by the Region and individual providers but also ensures that utilization is controlled.

Related Category 3 Outcome Measures

Based on our projected ability to contract with certain specialists available in the area, we have chosen outcome measures below:

Outcome Measure #1: IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (Standalone measure). Asthma affects about 19.6% of the Dallas County population and was identified as one of the top five conditions for cause of ED visits in the Region. We plan on measuring the improvement in Asthma for Baylor Clinic patients. At Baylor Health Care System, we have a standard set of Asthma metrics which consists of: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. We measure this yearly for our Asthma patients and calculate what we call: The Percent of Opportunity Achieved (POA). This is calculated by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population. POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in asthma management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their asthma patients than in the prior reporting period. For an illustrative example: For

Asthma- there are 4 opportunities (i.e. metrics) per patient (1) documentation of Action/Mgmt Plan, 2) Severity Assessment, 3) Controller Therapy for those who are eligible, and 4) Spirometry within last two years). The denominator would be # of patients x 4. So, for example, if there are 10 patients x 4 opportunities each = 40 opportunities to be achieved. If, in the course of the year, only 30 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 30/40=75%. To achieve a 10% improvement in POA, we would have to have completed at least 34/40 opportunities to get at 85% achievement.

Outcome Measure #2: IT-12.2 Cervical Cancer Screening (Non-Standalone Measure). In Dallas County, the incidence rate of cervical cancer is higher than the national average. In Dallas, the incidence rate of cervical cancer is 9.7 cases per 100,000 people[88]. According to the National Cancer Institute, African American women are more likely to be diagnosed with cervical cancer and Hispanic women have the highest cervical cancer incidence rate amongst all women[89]. There is opportunity to increase screenings in the minority population through engaging OB/GYNs to provide screenings and education. Additionally, these specialists can provide advanced screenings and education that would not be available in a PCP/PCMH setting.

Outcome Measure #3: IT-12.3 Colorectal cancer screening (Non-Standalone Measure). In Dallas County the incidence rate of colorectal cancer is 43.3 cases per 100,000. Only 60% of the population in Dallas County has regular colon screenings. It is the second leading cause of cancer related deaths in the US and as many as 60% of the deaths from colorectal cancer could be avoided with regular screening tests.[90] There is a definite need for these services in Dallas County and the Baylor Clinic plans to provide these screenings to a greater number of people. According to the Centers for Disease Control and Prevention, Hispanics and African Americans are less likely to get screened for colorectal cancer and it is often found in the latter stages of the disease as compared to their Caucasian counterparts[91]. There is an opportunity to increase the colorectal cancer screening rates by engaging specialists in the Dallas County area to provide these basic and advanced screenings along with education that is focused on this particular topic.

Relationship to other Projects

121776204.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
Increasing access to specialty care is related to the project of expanding primary care capacity for two reasons: 1) as more patients enter the PCMH, there will be an increase in the need for specialty care services and 2) primary care is essential to coordinate the specialty care and to allow for adequate follow-up for the patient, in order to avoid any complications or issues that may arise after the specialty care is received

Related Category 4 Population-focused improvements

[88] Healthy People North Texas: http://www.healthyntexas.org
[7] National Cancer Institute: http://www.cancer.gov/
[90] Healthy People North Texas: http://www.healthyntexas.org
[91] Centers for Disease Control and Prevention: http://www.cdc.gov/

RD-1.1, RD-1.4,RD-2.1, RD-2.4, RD-2.5, RD.2.7,RD-3.1, RD-3.3, RD-3.4, RD-3.5, RD-3.7, RD-3.8, RD-3.10, RD-3.11, RD-3.13, RD-3.14, RD-3.15, RD-3.16, RD-3.20, RD-3.21, RD-3.22, RD-3.27, RD-3.37, RD-3.38, RD-3.40, RD-3.41, RD-3.44, RD-3.45, RD-3.36, RD-3.48, RD-3.51, RD-3.52, RD-3.53.RD-4.1, RD-4.2

Relationship to Other Projects

- Baylor Medical Center at Carrollton (Trinity)
- Baylor Medical Center at Garland
- Baylor University Medical Center

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

- Parkland Health & Hospital Center – 127295703.1.5
- UT Southwestern – Faculty Practice Plan – 126686802.1.5

Our project does not serve the same specialty care population as the aforementioned projects.

Plan for Learning Collaborative: We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Baylor Medical Center at Irving has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor Medical Center at Irving defined the population that will be directly impacted by the project as underserved individuals in the Irving and Dallas County area that access to specialty care services. People who receive these services must be a patient of the Baylor Clinic prior to being referred to specialty care. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3. We believe this to be the correct number because, patients will receive the procedures, diagnostics, etc. that they previously

were unable to afford or could not have access to. To determine the value to the community, we concluded that, on a scale of 1 – 5, the value of this project is a ***3.*** We believe this to be the correct number because, fewer clinical exacerbations lead to less frequency of costly procedures and surgeries versus waiting for specialty care and having a more serious condition occur.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121776204.1.2	***1.9.2***	***1.9.2 (A-D)***	***IMPROVE ACCESS TO SPECIALTY CARE-***EXPAND SPECIALTY CARE SERVICES	
Baylor Medical Center at Irving				*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.6*	*3.IT-11.1*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider-Asthma Improvement (Standalone measure)*	
	121776204.3.7	*3.IT-12.2*	*-Cervical Cancer Screening (Non-Standalone Measure)*	
	121776204.3.8	*3.IT-12.3*	*-Colorectal cancer screening (Non-Standalone Measure)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct specialty care gap assessment based on community need Metric 1 [P-1.1]: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline/Goal: Documentation of gap assessment based on Baylor Clinic patient need and how this coincides with Regional needs Data Source: E.H.R Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 150,244 **Milestone 2** [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: Determine current wait time for specialty care services by specialty Data Source: E.H.R (chart review) Milestone 2 Estimated Incentive Payment *(maximum amount):*	**Milestone 3** [P-5]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment Metric 1 [P-5.1]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians. Baseline/Goal: Determine average referral time for patients that were seen in DY3. This metric is the subsequent step to **P-3.1**. Data Source: E.H.R Milestone 3 Estimated Incentive Payment: $ 109,272 **Milestone 4** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 3 providers or facilities to provide	**Milestone 6** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 6 providers or facilities to provide specialty care services (over DY2) Data Source: Documentation of implemented contracts Milestone 6 Estimated Incentive Payment: $ 164,384 **Milestone 7** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Provide at least **169** unduplicated patients with specialty	**Milestone 8** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 9 providers or facilities to provide specialty care services (over DY2) Data Source: Documentation of implemented contracts Milestone 8 Estimated Incentive Payment: $ 135,796 **Milestone 9** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Provide at least **261**

121776204.1.2	***1.9.2***	***1.9.2 (A-D)***	***IMPROVE ACCESS TO SPECIALTY CARE-*** EXPAND SPECIALTY CARE SERVICES	
Baylor Medical Center at Irving				*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.6* *121776204.3.7* *121776204.3.8*	*3.IT-11.1* *3.IT-12.2* *3.IT-12.3*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider-Asthma Improvement (Standalone measure)* *-Cervical Cancer Screening (Non-Standalone Measure)* *-Colorectal cancer screening (Non-Standalone Measure)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
$ 150,244	specialty care services (over DY2) Data Source: Documentation of implemented contracts Milestone 4 Estimated Incentive Payment: $109,272 **Milestone 5** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Provide at least **82** unduplicated patients with specialty care services over DY2 Data Source: E.H.R Milestone 5 Estimated Incentive Payment: : $109,271	care services over DY2 Data Source: E.H.R Milestone 7 Estimated Incentive Payment: $164,384	unduplicated patients with specialty care services over DY2 Data Source: E.H.R Milestone 9 Estimated Incentive Payment: $ 135,796
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 300,487	Year 3 Estimated Milestone Bundle Amount: $ 327,815	Year 4 Estimated Milestone Bundle Amount: $ 328,768	Year 5 Estimated Milestone Bundle Amount: $ 271,591

121776204.1.2	***1.9.2***	***1.9.2 (A-D)***	***IMPROVE ACCESS TO SPECIALTY CARE-***EXPAND SPECIALTY CARE SERVICES	
Baylor Medical Center at Irving				*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.6*	*3.IT-11.1*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider-Asthma Improvement (Standalone measure)*	
	121776204.3.7	*3.IT-12.2*	*-Cervical Cancer Screening (Non-Standalone Measure)*	
	121776204.3.8	*3.IT-12.3*	*-Colorectal cancer screening (Non-Standalone Measure)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,228,661				

Project Option 1.1.2 - Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

Unique Project ID: 139485012.1.1
Performing Provider Name/TPI: Baylor University Medical Center/139485012

Provider: Baylor University Medical Center at Dallas is a nationally recognized hospital that cares for more than 300,000 people each year. Baylor Dallas has 1,065 licensed beds and serves as the flagship hospital of Baylor Health Care System. Located in Dallas, Baylor Dallas' service area represents a population of 4.2 million.

Intervention(s): This project will implement increased access to three (3) Patient-Centered Medical Home (PCMH) clinics designed to provide comprehensive and high-quality primary care services to underserved patients in the Baylor University Medical Center service area. The project is an expansion of Baylor's Clinic strategy in Dallas County. Historically, Baylor's Community Care clinics have provided access to patients following discharge from Baylor University Medical Center. This expansion will focus on the recruitment of more underserved (Medicaid/Uninsured) patients from the community at-large and patients awaiting access to other public resources.

Need for the project: Access to quality primary care services has been demonstrated to improve health outcomes and reduce avoidable hospital utilization among underserved patient populations.This project will increase access to a PCMH for more patients in the community.

Target population: The 872,000 uninsured and Medicaid population in Dallas County without a PCP/PCMH. Clinic capacity will allow approximately 1600 new patients per year. We expect that about 90-95% of the new patients/year will be uninsured/Medicaid patients.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide access to an anticipated 4,800 new patients from the Dallas community.

Category 3 outcomes: Category 3 outcomes for this project were chosen because: 1) the ambulatory setting of the project and 2) historical trends of metrics that had material impact on patients in a 2-3 year time period. All baselines will be reevaluated and reestablished in DY2.

- IT-1.7: Controlling High Blood Pressure. Our goal is to increase the number of patients with controlled blood pressure (< 140/80 mmHg) from 52.2% currently to 59.0% in DY5 (or a total of 7% improvement over established baseline).
- IT-6.1: Percent Improvement over baseline of patient satisfaction scores (clinic wait times). Our goal is to increase patient satisfaction from 83.8% currently to 86.1% in DY5 (or a total of 2.3% improvement over established baseline).

- IT-6.1: Percent Improvement over baseline of patient satisfaction scores (timely response to patient phone calls). Our goal is to increase patient satisfaction from 85.2% currently to 87.3% in DY5 (or a total of 2.1% improvement over established baseline).

- IT-12.1: Breast Cancer Screening. Our goal is to increase the number of appropriate women who receive breast cancer screenings from 58.7% currently to 64.6% in DY5 (or a total of 5.9% improvement over established baseline).

- IT-12.5: Other USPSTF screening outcome (Influenza Vaccination). Our goal is to increase the number of adults 18 and over who receive an influenza vaccination from 52.5% currently to 59.3% in DY5 (or a total of 6.8% improvement over established baseline)

Project Description

The Baylor Clinic on the Baylor University Medical Center campus, would expand their current capacity by opening their patient panels to non-Baylor patients (including Medicaid and Uninsured) and fully utilize the space and providers' capacity. Additional support staff will be hired to better coordinate patient care, ensure transition from the hospital to a Baylor Clinic and help to facilitate the care of the complex underserved patients. The Baylor Clinic on the Baylor University Medical Center is already an NCQA recognized PCMH, thus the focus of this project would be to open the current panel to the underserved community and provide volume relief for other providers/ health systems in the area. We expect that approximately 90-95% of new patients will be Medicaid/Uninsured. Additionally, the clinic would provide these high quality primary care services to a greater number of people. Essentially, through expanding the capacity of the current clinic, adding additional support staff and services, a patient can receive comprehensive and complete services in one primary care location. In addition to receiving primary care, this project also proposes that ancillary services such as labs, imaging (i.e. CT scans, MRI, ultrasound, etc.) and diagnostics (i.e. colonoscopy, stress tests, etc.) would also be provided upon physician request. This project aims to close the loop of care and increase patient compliance by co-locating/coordinating many of the essential services that the underserved population often has issues accessing and completing.

Goals and Relationship to Regional Goals

The 5 year goals of this project are: (1) to provide a PCMH and PCP to a greater number of the underserved population, (2) provide continuity and transition to post-acute care services, (3) improve patients' health outcomes and status (4) create an integrated primary care model for underserved patients in Dallas County to receive high quality, complete care keeping these patients from utilizing the emergency department for low acuity needs and preventing re(admissions) that could have been avoided with proper primary care. The Region has a primary care provider and capacity issue for the underserved population. This project aims to address increasing access to primary care and providing high quality, comprehensive care to patients in a less costly setting. ED utilization is high in RHP 9 and increasing primary care access will keep them from using the ED as a means to receive basic care.

Challenges

Providers and hospitals are reluctant to expand primary care capacity in charity clinics due to the inherent necessity for other downstream services, procedures, and costs associated with adding a patient with multiple, complex needs from the underserved population. Basic primary care needs are unable to be fulfilled because of the lack of funding and capacity to take more patients, thus leading to increased (re)admissions and prevalence of disease complications. Lastly, due to the transient nature of this population, it is difficult to achieve the full extent of quality and clinical outcomes associated with a Patient Centered Medical Home. This project addresses these challenges by creating a low-cost, effective, co-located and comprehensive model specifically for the underserved population.

5-year expected outcome for the performing provider and patients

At the end of 5-years, 4800 new, unduplicated patients will have received PCMH/primary care services at the Baylor Clinics on the Baylor University Medical Center Campus. We expect that at least 15% of patients who continue to come to the Baylor Clinics will achieve better Adult Preventive Scores (APS) and have overall better clinical outcomes.

Starting Point/Baseline

From July 2010 to June 2011, the Baylor Clinics on the Baylor University Medical Center served over 1900 unduplicated patients. To date, there has not been a formal process to take patients from the community; capacity is typically reserved for those patients that come from a Baylor University Medical Center ED. In addition to patients discharged from Baylor University Medical Center, we will focus on 4800 of the 872,000+ patients that are uninsured in Dallas County.[92] We plan on recruiting patients into our Baylor Clinics through a combination of utilizing our inpatient care navigation services and furthering relationships with community partners. Currently, we have Care Navigators which proactively identify potential hospital patients that would be candidates to be seen in a Baylor Clinic. Also, through the expansion of project 139485012.2.3 (navigation services for high risk patients), will provide additional patients to be seen at the Baylor Clinic. Lastly, our relationship with other providers and community partners will also serve as a referral source into the clinic.

We chose this project option because of the demonstrated need in the RHP and to leverage our PCP/PCMH model to patients outside of the Baylor system. According to the Community Health Needs Assessment, 100% of the counties in the region are designated as medically underserved areas and 36.1% of individuals in Dallas County are uninsured.[93] The combination of these two factors leads to increased ED utilization and clinical complications due to lack of adequate access to coordinated, primary care services. According to the Dallas Fort Worth Hospital Council database, 68% of ED visits related to the top conditions in the county were non-emergent /primary care treatable. The top five conditions from the ED that resulted in an inpatient admission were: stroke, diabetes, congestive heart failure, weak/failing kidneys,

[92] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/48439.html

[93] RHP 9 Community Health Needs Assessment

chronic bronchitis and heart attack. These services can be better coordinated and managed in a primary care setting, ensuring 1) the patient receives needed care, 2) adequate follow-up is provided and 3) services are provided in timely fashion so that long term disease complications and other issues are avoided. Baylor Clinics have a proven track record for improving patient outcomes and creating primary care capacity in underserved areas. Expanding these services to non-Baylor patients would be a service to the community and patients. This project is a low-cost, high-quality solution to a pressing need in the community.

Project Components

The three main core components of this project include:

a) *Expand primary care clinic space:* We will not be physically expanding the primary care clinic space, but we will be more fully utilizing the current space we have and will take advantage of underutilized space in the Baylor Clinic to see more patients. By carving out space to handle non-clinical needs such as finding community resources, education, coordinating care/appointments, etc., this will allow more room for providers to see patients and handle clinical needs.

b) *Expand primary care clinic hours:* We plan to expand our hours through the expansion of care teams. By adding mid-levels and other non-physician support staff, there will be more provider hours available, more appointment availability through expanding our current capacity from two appointment slots an hour to four (for example).

c) *Expand primary care clinic staffing*. We plan on hiring at least 2 FTEs to add to the care team in Dallas in order to increase our capacity and services offered. We also plan to make the current staff hours more efficient so that more appointments per hour can be offered to patients.

The Baylor Clinics at Baylor University Medical Center are NCQA recognized[94], thus the focus of the metrics is on further improving and refining the PCMH baseline that has been established. Improvement metrics that hone in on increasing capacity, patient satisfaction and serving more patients are the impetus of this project. We also plan on engaging in continuous quality improvement activities on a regular basis that focus on: 1) identifying key challenges with the expansion of this project, 2) determine opportunities to scale all or part of the project-depending on available resources and financial constraints and 3) look for ways to increase efficiency and effectiveness.

Specify the unique community need identification number the project addresses:

CN.3- Healthcare Capacity, CN.12-ED Usage and Readmissions

How the Project significantly enhances an existing delivery system reform initiative

This project has not received any funding from any federal source. It enhances current delivery system reform initiative by focusing on providing high quality, low cost and comprehensive services to the underserved population. It encourages decreased utilization of unnecessary specialty care, ED utilization and promotes better preventive services to avoid downstream

[94] NCQA: http://www.ncqa.org

complications and costs. It exemplifies the Triple Aim from the Institute of Healthcare Improvement's three components of better care, better health and lower cost.

Related Category 3 Outcome Measures

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients got a PCMH at a Baylor Clinic.

Outcome Measure #1: IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone measure). Controlling high blood pressure is essential in avoiding heart attacks, stroke, heart failure and a multitude of other diseases and complications. Through medication management, proper primary care attention and education, patients can achieve better blood pressure control in the outpatient setting. In Region 9, Hypertension was identified as one of the top 5 most prevalent diseases in the area for ED admissions.[95] A recent article in the New York Times suggested that hypertensive complications can be especially deadly in the African American population,[96] who make up 22.5% of the RHP 9 population. Patients who are uncontrolled will receive the attention they need to get their hypertension under control. Patients will receive medication management, lifestyle management techniques and education about their illness in this clinic PCMH setting.

Outcome Measure #2 and #3: IT-6.1: Percent Improvement over baseline of patient satisfaction scores (Standalone measure). Outcome Measure #2 will measure: *Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Clinic Wait Times.* Outcome Measure #3 will measure: *Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Response Time to Patient Phone Calls.* Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Data from Press Ganey Associates in 2007[97] has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less physician/staff time, reducing length of visits and wait times for the overall practice. Baylor Clinics have historically had high performance in all measures related to patient satisfaction however there is opportunity for improvement. This outcome has an impact on the region through increasing utilization of outpatient based primary care. If patients are satisfied, they will continue to come to their appointments, stay healthier and stay out of the ED.

[95] RHP 9 Community Health Needs Assessment

[96] http://health.nytimes.com/health/guides/disease/hypertension/complications.html

[97] Drain, M., & Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

The following two outcome measures focus on adult preventive services. Adult Preventive services as recommended by USPSTF are low cost, highly effective interventions that prevent and maintain patients' health status. Patients who are a part of a Baylor PCMH are routinely screened and monitored to ensure that they are receiving all preventive services that are appropriate for their age and condition.

Outcome Measure #4: IT-12.1 Breast Cancer Screening (Non-Standalone Measure). In Dallas County, 23.7/100,000 women die from breast cancer with the rate in African American at 37/100,000. This statistic is considered to be higher than the national average. There is room for improvement with this metric to screen more women and utilize early detection methods for breast cancer.[98]

Outcome Measure #5: IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate). In Dallas County, only 65% of individuals over the age of 18 received an influenza vaccination in the past 12 months.[99] The rate of influenza vaccinations in the Region is quite low and there is an opportunity to increase the number in the target population that receive this basic vaccination in order to prevent exacerbations of health issues, reduce the prevalence of influenza and prevent ED visits related to influenza that can otherwise be handled in an outpatient setting.

Relationship to Other Projects

139485012.2.1 Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program: The Chronic Care Management model will be integrated to ensure that high risk patients with chronic disease would be identified, addressed and managed.

PASS 2: 139485012.2.4 Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs - Vulnerable Patient Network (Home Visit Program)

139485012.1.2- Improve Access to Specialty Care-Expand Specialty Care Services Improving access to specialty care is essential so patients can receive coordinated care/referrals to these services and necessary follow-up required for continuity of care in a primary care clinic setting.

139485012.2.2- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment

The project involving developing care management functions to integrate primary and behavioral health is related - services will be integrated and a standard part of patient care.

Related Category 4 Population-focused improvements

RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.7, RD-1.8, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7, RD-3.1, RD-3.5, RD-3.6, RD-3.10, RD-3.11, RD-3.22, RD-3.26, RD-3.36, RD-4.1, RD-4.2

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

[98] Healthy North Texas: www.healthyntexas.org

[99] RHP 9 Community Health Needs Assessment

Performing Provider	Unique Project ID
Baylor Medical Center at Garland	121790303.1.1
Baylor Medical Center at Irving	121776204.1.1
Baylor Medical Center at Carrollton (Trinity)	195018001.1.1
Baylor University Medical Center	139485012.1.1
Children's Medical Center	138910807.1.1
Children's Medical Center	138910807.1.2
Medical City Dallas (HCA)	020943901.1.3
Parkland Health & Hospital System	127295703.1.1
Parkland Health & Hospital System	127295703.1.2
Parkland Health & Hospital System	127295703.1.6
Parkland Health & Hospital System	127295703.1.1
Texas Health Presbyterian – Dallas	020908201.1.1
UT Southwestern Medical Center Faculty Plan	126686802.1.1
UT Southwestern Medical Center Faculty Plan	126686802.1.2

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. The exchange of best practices and shared learning contributes significantly to CQI and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced our projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. This methodology is consistent with our approach in our other RHPs. Baylor University Medical Center has computed the value of this project using the model developed at the Regional level.

Baylor University Medical Center defined the population that will be directly impacted by the project as 4800 underserved patients in the Dallas area of the 872,000+ uninsured in Dallas County. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***4.*** We believe because this project entails providing a basic PCP/PCMH setting for underserved patients who do not have one, this alone has a large impact on the individual in being able to meet basic healthcare needs and receive the medical attention they need to sustain their health. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***4.*** We believe this is correct because, when a person is positively impacted, their dependence on community resources is better utilized and over time, will decrease. When these patients

receive healthcare, they are able to manage their conditions better, remain productive members of society, stay out of the ED and avoid costly clinical exacerbations.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

139485012.1.1	***1.1.2***	***1.1.2 (A-C)***	***EXPAND EXISTING PRIMARY CARE CAPACITY-****BAYLOR CLINIC CAPACITY EXPANSION*	
	Baylor University Medical Center			***139485012***
Related Category 3 Outcome Measure(s):	*139485012.3.1* *139485012.3.2* *139485012.3.3* *139485012.3.4* *139485012.3.5*	*3.IT-1.7* *3.IT-6.1(1)* *3.IT-6.1 (2)* *3.IT-12.1* *3.IT-12.5*	*Controlling high blood pressure (Standalone measure)* *Percent improvement over baseline of patient satisfaction scores (Standalone)* *Percent improvement over baseline of patient satisfaction scores (Standalone)* *Breast Cancer Screening (Non-Standalone measure)* *Other USPSTF screening outcome (Influenza Vaccination) (Non-Standalone)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Establish additional/expand existing/relocate primary care clinics Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Baseline/Goal: Determine optimal usage of clinic space and shift utilization based on clinical need (i.e.: carve out space for consults and non-clinical issues to allow more space for providers to see a greater number of patients) Data Source: Documentation of space re-allocation/increased utilization plans Determine provider capacity to hold at least one evening clinic a week Milestone 1 Estimated Incentive Payment: $1,028,892 **Milestone 2** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric 1 [P-5.1]: Documentation of		**Milestone 3** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum **1600** new, unduplicated patients will be seen at the Baylor Clinic over baseline Data Source: E.H.R Milestone 3 Estimated Incentive Payment: $1,222,465 **Milestone 4** [I-15]: Increase access to primary care capacity. Metric 1 [I-15.1]: Increase percentage of target population reached. Goal: Increase access to 15% of available Baylor Clinic capacity to eligible community patients (non-Baylor patients)	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum **3200** new patients will be seen at the Baylor Clinic (cumulative over baseline) Data Source: E.H.R Milestone 5 Estimated Incentive Payment: $1,125,728 **Milestone 6** [I-15]: Increase access to primary care capacity. Metric 1 [I-15.1]: Increase percentage of target population reached. Goal: Increase access to 20% of available Baylor Clinic capacity to eligible community patients (non-Baylor patients)	**Milestone 7** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.2**]:** Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum **4800** new patients will be seen at the Baylor Clinic (cumulative over baseline) Data Source: E.H.R Milestone 7 Estimated Incentive Payment: $929,950 **Milestone 8** [I-15]: Increase access to primary care capacity. Metric 1 [I-15.1]: Increase percentage of target population reached. Goal: Increase access to 25% of available Baylor Clinic capacity to eligible community patients (non-Baylor patients) Data Source: Electronic Tracking/E.H.R

139485012.1.1	***1.1.2***	***1.1.2 (A-C)***	***EXPAND EXISTING PRIMARY CARE CAPACITY-****BAYLOR CLINIC CAPACITY EXPANSION*	
Baylor University Medical Center				***139485012***
Related Category 3 Outcome Measure(s):	*139485012.3.1* *139485012.3.2* *139485012.3.3* *139485012.3.4* *139485012.3.5*	*3.IT-1.7* *3.IT-6.1(1)* *3.IT-6.1 (2)* *3.IT-12.1* *3.IT-12.5*	*Controlling high blood pressure (Standalone measure)* *Percent improvement over baseline of patient satisfaction scores (Standalone)* *Percent improvement over baseline of patient satisfaction scores (Standalone)* *Breast Cancer Screening (Non-Standalone measure)* *Other USPSTF screening outcome (Influenza Vaccination) (Non-Standalone)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
increased number of providers and staff and/or clinic sites. Baseline/Goal: 2.5 new FTEs Data source: Documentation of hired employees Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,028,892		Data Source: Electronic Tracking/E.H.R Milestone 4 Estimated Incentive Payment: $1,222,465	Data Source: Electronic Tracking/E.H.R Milestone 6 Estimated Incentive Payment: $1,125,728	Milestone 8 Estimated Incentive Payment: $929,950
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,057,783		Year 3 Estimated Milestone Bundle Amount: $2,244,930	Year 4 Estimated Milestone Bundle Amount: $2,251,456	Year 5 Estimated Milestone Bundle Amount: $1,859,899
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $8,414,068				

Project Option 1.9.2 - Improve Access to Specialty Care-Expand Specialty Care Services

Unique Project ID: 139485012.1.2
Performing Provider Name/TPI: Baylor University Medical Center/139485012

Provider: Baylor University Medical Center at Dallas (Baylor Dallas) is hospital that cares for more than 300,000 people each year. It is a major patient care, teaching and research center for the Southwest. Baylor Dallas has 1,065 licensed beds and serves as the flagship hospital of Baylor Health Care System. Located in Dallas, Baylor Dallas' service area represents a population of 4.2 million.

Intervention(s): This project will increase access to needed specialty care services (i.e. outpatient visits with specialty physicians, hospital-based procedures) for uninsured patients under the care of a Baylor clinics in Dallas. This is a new project and will provide specialty services previously unattainable for Medicaid/Uninsured patients.

Need for the project: Specialty services are a key element to providing a full continuum of care to patients (beyond what can be provided in a primary care clinic) and an important contributor to improved health outcomes and avoidance of costly clinical exacerbations. Shortage of specialty care was one of the key health needs identified in the RHP.

Target population: The target population will be a subset of established Baylor clinic patients who require specialty services. While historical data suggests 10-15% of all established patients will develop a need for specialty services, constraints in available specialists and facilities should allow the project to serve approximately 5% of all established patients within a given year. Baylor Clinic patients are typically 90-95% Uninsured/Medicaid. 95% of patients in this specialty care project will be Uninsured/Medicaid.

Category 1 or 2 expected patient benefits: Over the course of DY3-DY5 an estimated 400 individual patients will be connected to specialty care services. This project will make the specialist part of the primary care team.

Category 3 outcomes: The Category 3 outcomes for this project were chosen because: 1) historical data from similar programs with specialists and 2) outcomes that have potential to show material improvement over a 2-3 year time period.

- IT-11.1: Improvement in Clinical Indicator in identified disparity group: Improvement in Asthma Bundle. Our goal is to improve performance of our Asthma metrics Percent of Opportunities Achieved (POA) from 30% completed opportunities currently to 40% (or 10% improvement over baseline) completed opportunities in DY5.

- IT-12.2: Cervical Cancer Screening. Our goal is to increase the number of appropriate women receive screenings from 68.9% currently to 73.3% (or 4.4% improvement over baseline) in DY5.

- IT-12.3: Colorectal Cancer Screening. Our goal is to increase the percentage of appropriate patients receive screenings from 49% currently to 56.3% (or 7.3% improvement over baseline) in DY5.

Project Description

Patients (including Medicaid and Uninsured) who are seen at a Baylor Clinic and have an established PCMH, can receive specialty care services such as outpatient procedures, specialty office visits, wound care, and facility based procedures such as cardiac catheterizations, certain surgeries (i.e.: gall bladder/hernia), excision of masses (breast, lymphoma), and cataract removal. This project excludes transplants, oncology and perinatal services. The specialty care referral/coordination will come from the PCMH clinic per PCP's request. We expect approximately 95% of patients that will receive specialty care will be Uninsured/Medicaid. This project is more than just providing specialty care to patients. Much of the value comes from building relationships, contracts and a network with local specialty care providers that can be easily accessible to this population. For Baylor University Medical Center, one of the goals we have included in the project was to contract with at least 12 providers in the community to create this specialty care network for the underserved population. Another facet of the project includes trying to make the specialist part of the primary care team. Through utilizing our electronic health record and specialty care referral coordinator, we hope engage specialists that provide procedures to also participate in the screening and educational needs of these patients. This is why we included Category 3 outcomes around Asthma improvement, Cervical and Colorectal cancer screening. We believe engaging specialists in these types of preventive services will help to integrate them into the primary care team. Sharing feedback through the electronic health record also will help to create a central repository of patient information and allow the care team to track and improve patient outcomes. Lastly, we expect value to come avoiding ED visits and more serious specialty care needs due to clinical exacerbations from not receiving timely and effective care. Almost $74.9 million dollars in total costs were spent on inpatient visits and procedures (excluding any maternal/newborn procedures) that Medicaid/Uninsured patients received at Baylor University Medical Center at Dallas from July of 2011 to June of 2012.

Goals and Relationship to Regional Goals

The goals for this project are to 1) increase/improve access to specialty care services, 2) engage a greater number of providers/facilities to provide these services, 3) increase the number of completed specialty referrals for patients and 4) improve disease specific clinical outcomes affected by increased access to target specialists. As a result, we expect that more patients will have a better quality of life when they are given the appropriate specialty care, in a timely manner and in the appropriate venue. By managing the patient and coordinating the care

through the PCMH, we expect the patient will have fewer complications post procedure. According to the Community Health Needs Assessment, the demand for primary and specialty care services exceeds that of available physicians, thus limiting healthcare access for many low level management or specialized treatments for health conditions[100]. This project would help to offset some of the demand for specialty care services and do so in a coordinated and meaningful way. The patients who need specialty care services, both inpatient and outpatient, would require a referral from their Baylor Clinic PCMH in order to receive the procedure and then also be able to follow-up with their PCP after the procedure/test is completed. This synchronizes with regional needs of providing access to more specialty care and also coordinates the care for the patient to ensure compliance timely care. As patients receive specialty care they need, it is likely clinical exacerbations of manageable conditions will decrease, lowering the cost of care in more expensive settings.

Challenges

The major challenges with providing increased access to specialty care are multiple: 1) lack of supply of specialty providers in the Region and even smaller supply who are willing to provide specialty care services to this population, 2) specialty care is expensive to provide for patients who have little or no ability to pay, 3) long wait lists to receive specialty care lead to clinical exacerbations due to less timely care and 4) no coordination or follow-up for patients who do receive specialty care leading to infections, healing issues and lack of wound management which can often lead to a hospital (re)admission. Through developing community relationships with providers and facilities in the area, we plan to find ways to provide more access points for these patients to receive the care they need, in a timely manner so that we are can monitor utilization and outcomes and be good stewards of limited specialty care resources.

5-year expected outcome for the performing provider and patients

The 5 year expected outcome is to provide specialty care to approximately 400 unduplicated patients over the waiver period by increasing the number of providers/facilities contracted to at least 12. We also expect to increase the number of completed referrals for specialty care services 20% over baseline. Lastly, we expect to help facilitate the coordination and collaboration of specialists and primary care providers for our patients. We hope that by engaging specialists to do more complex procedures as well as preventive services that this will help create a more robust care team that will benefit the entire community.

Starting Point/Baseline

Currently, specialty referrals have been coordinated on a case-by-case basis with a limited network of specialty care providers and Baylor University Medical Center. The baseline, therefore has not been closely tracked. A major focus of this project will be to more accurately capture baseline data and formalize the specialty care referral process. Historic data on specialty care demand amongst Baylor Clinic patients suggests that 10-15% of all patients develop a need for specialty care services at some point in their care. The constraints of limited

[100] RHP 9 Community Health Needs Assessment

specialty care providers and facilities willing to care for this population have allowed similar programs in the area to meet demand for approximately 5% of a clinic's patient population.

Rationale

A key strategy for the Baylor Clinics has been the expansion of primary care access for the underserved population. Increased access to primary care has been strongly correlated with better health outcomes and lower avoidable hospital utilization within this patient population. While primary care providers are able to manage and treat many conditions, historic experience suggests that 10-15% of a clinic's patient population will likely develop a specialty care need at some point. Left untreated, this 10-15% of patients is likely to develop further exacerbation of health problems, experience more complications and increase the likelihood of avoidable hospital utilization. This project will supplement our goals of engaging specialty care physicians in providing the more advanced procedures/screenings and to conduct some basic preventive screenings and patient education. This will make specialists a formal part of the care team. Baylor Clinics have established relationships with providers in the community and as we grow, we will expand those relationships to serve more patients. As Baylor Clinics take more patients from the community, there will be an increased need for specialty care services in this population. This project proactively creates increased specialty access for these new patients as well established clinic patients who have historically had poor access to specialty care.

Project Components

We will complete all required project components for the expansion of specialty care project:

a) Increase service availability with extended hours: we will increase service availability by offering more appointments to patients in the outpatient setting and coordinate with surrounding hospitals to provide the inpatient services the patient may need

b) Increase number of specialty clinic locations: we plan to contract with at least 12 providers/facilities over the course of the waiver, providing more locations for patients to receive the specialty care they need

c) Implement transparent, standardized referral processes across the system: we have a standard referral form and process documented in the EHR and visible to staff and will work to improve tracking, reporting and collection of referral data

d) Conduct quality improvement for project using methods such as rapid cycle improvement: we will engage in 1) identifying key challenges with project expansion, 2) determine opportunities to scale all or part of the project- depending on available resources/financial constraints, 3) identify ways to integrate specialists into care team

The milestones and metrics chosen for this project really focus on improvement of coordinating the care for patients to receive specialty care and more of it. The Region has demonstrated a need to improve access to specialty care and fulfill some of the gaps that have been identified

in the care that is unavailable. Our metrics and milestones are structured as such and the specialties identified will be a priority as the project progresses and more facilities/providers are contracted with to provide these services. The other metrics focus on increasing the number of appropriate referrals which entails identifying patients early on when certain minor procedures can be completed in lieu of the more expensive alternatives. Lastly, we have set specific metrics around the number of patients that will be served in order to ensure that on top of referrals, actual patient lives are impacted and specialty care is delivered.

Unique community need identification number the project addresses
CN.3- Healthcare Capacity, CN.9- Specialty Care

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

This project does not receive any source of federal funding and has been identified as a significant Regional need. It enhances the existing delivery system reform initiative by coordinating specialty care through a primary care setting; thus managing utilization, costs and reducing complications for patients. This project would supply the specialty care needs identified by the Region and individual providers but also ensures that utilization is controlled.

Related Category 3 Outcome Measures
Based on our projected ability to contract with certain specialists available in the area, we have chosen outcome measures below that will be addressed upon establishing relationships with the specialties mentioned below.

Outcome Measure #1: IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (Standalone measure). We plan on measuring the improvement in Asthma for Baylor Clinic patients. Asthma affects about 19.6% of the Dallas County population and was identified as one of the top five conditions for cause of ED visits in the Region. Approximately 90.1% of these ED visits related to Asthma could have been handled in the outpatient setting. [101] At Baylor Health Care System, we have standard Asthma metrics: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. We measure this yearly for our Asthma patients and calculate what we call: The Percent of Opportunity Achieved (POA). This is calculated by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population. POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in asthma management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets

[101] RHP 9 Community Health Needs Assessment

for their asthma patients than in the prior reporting period. For an illustrative example: For Asthma- there are 4 opportunities (i.e. metrics) per patient (1) documentation of Action/Mgmt Plan, 2) Severity Assessment, 3) Controller Therapy for those who are eligible, and 4) Spirometry within last two years). The denominator would be # of patients x 4. So, for example, if there are 10 patients x 4 opportunities each = 40 opportunities to be achieved. If, in the course of the year, only 30 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 30/40=75%. To achieve a 10% improvement in POA, we would have to have completed at least 34/40 opportunities to get at 85% achievement.

Outcome Measure #2: IT-12.2 Cervical Cancer Screening (Non-Standalone Measure). In Dallas County, the incidence rate of cervical cancer is higher than the national average. In Dallas, the incidence rate of cervical cancer is 9.7 cases per 100,000 people.[102] According to the National Cancer Institute, African American women are more likely to be diagnosed with cervical cancer and Hispanic women have the highest cervical cancer incidence rate amongst all women[103]. There is opportunity to increase the screenings in the minority population through engaging OB/GYNs to provide screenings and education for this population. Additionally, these specialists can provide advanced screenings/education that would not be available in a PCP/PCMH setting.

Outcome Measure #3: IT-12.3 Colorectal cancer screening (Non-Standalone Measure). In Dallas County the incidence rate of colorectal cancer is 43.3 cases per 100,000. Only 60% of the population in Dallas County has regular colon screenings. It is the second leading cause of cancer related deaths in the US and as many as 60% of the deaths from colorectal cancer could be avoided with regular screening tests.[104] There is a definite need for these services in Dallas County and the Baylor Clinic plans to provide these screenings to a greater number of people. There is greater need for patients to receive (appropriate) sigmoidoscopies/ colonoscopies in the region as a preventive measure. According to the Centers for Disease Control and Prevention, Hispanics and African Americans are less likely to get screened for colorectal cancer and it is often found in the latter stages of the disease as compared to their Caucasian counterparts[105]. There is an opportunity to increase the colorectal cancer screening rates by engaging specialists in the Dallas County area to provide these basic and advanced screenings along with education that is focused on this particular topic.

Relationship to other Projects

139485012.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
Increasing access to specialty care is related to the project of expanding primary care capacity for two reasons: 1) as more patients enter the PCMH, there will be an increase in specialty care need and 2) primary care is essential to coordinate specialty care and allow for adequate follow-up to avoid any complications or issues that may arise after the specialty care is received

[102] Healthy People North Texas: http://www.healthyntexas.org
[7] National Cancer Institute: http://www.cancer.gov/
[104] Healthy People North Texas: http://www.healthyntexas.org
[105] Centers for Disease Control and Prevention: http://www.cdc.gov/

Related Category 4 Population-focused improvements

RD-1.1, RD-1.4, RD-2.1, RD-2.4, RD-2.5, RD.2.7,RD-3.1, RD-3.3, RD-3.4, RD-3.5, RD-3.7, RD-3.8, RD-3.10, RD-3.11, RD-3.13, RD-3.14, RD-3.15, RD-3.16, RD-3.20, RD-3.21, RD-3.22, RD-3.27, RD-3.37, RD-3.38, RD-3.40, RD-3.41, RD-3.44, RD-3.45, RD-3.36, RD-3.48, RD-3.51, RD-3.52, RD-3.53,RD-4.1, RD-4.2

Relationship to Other Projects

In addition to Baylor University Medical Center, projects to expand specialty care include:

- Baylor Medical Center at Carrollton (Trinity)
- Baylor Medical Center at Garland
- Baylor Medical Center at Irving

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

The following providers have projects to expand specialty care access:

- Parkland Health & Hospital Center – 127295703.1.5
- UT Southwestern – Faculty Practice Plan – 126686802.1.5

Our project aims to open access to patients who could not otherwise receive the specialty care they need and will require coordination and collaboration with other performing providers in the region. Our project does not serve the same specialty care population as the aforementioned project.

Plan for Learning Collaborative.

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. The exchange of best practices and shared learning will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Baylor University Medical Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor University Medical Center defined the population that will be directly impacted by the project as underserved individuals in the Dallas and Dallas County area that access to specialty care services. People who receive these services must be a patient of the Baylor Clinic prior to being referred to specialty care. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3. We believe this to be the correct number because, patients will receive the procedures, diagnostics, etc. that they previously were unable to afford or could not have access to. To determine the value to the community, we concluded that, on a scale of 1 – 5, the value of this project is a ***3.*** We believe this to be the correct number because, fewer clinical exacerbations lead to less frequency of costly procedures and surgeries versus waiting for specialty care and having a more serious condition occur.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

139485012.1.2	***1.9.2***	***1.9.2 (A-D)***	***IMPROVE ACCESS TO SPECIALTY CARE-*** EXPAND SPECIALTY CARE SERVICES	
Baylor University Medical Center				*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.6*	*3.IT-11.1*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider-Asthma Improvement (Standalone measure)*	
	139485012.3.7	*3.IT-12.2*	*-Cervical Cancer Screening (Non-Standalone Measure)*	
	139485012.3.8	*3.IT-12.3*	*-Colorectal cancer screening (Non-Standalone Measure)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct specialty care gap assessment based on community need Metric 1 [P-1.1]: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline/Goal: Documentation of gap assessment based on Baylor Clinic patient need and how this coincides with Regional needs Data Source: E.H.R Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 890,387 **Milestone 2** [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: Determine current wait time for specialty care services by specialty Data Source: E.H.R (chart review) Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 890,387	**Milestone 3** [P-5]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment Metric 1 [P-5.1]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians. Baseline/Goal: Determine average referral time for patients that were seen in DY3. This metric is the subsequent step to **P-3.1**. Data Source: E.H.R Milestone 3 Estimated Incentive Payment: $ 647,576 **Milestone 4** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 6 providers or facilities to provide specialty care services (over DY2) Data Source: Documentation of	**Milestone 6** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 9 providers or facilities to provide specialty care services (over DY2) Data Source: Documentation of implemented contracts Milestone 6 Estimated Incentive Payment: $ 974,188 **Milestone 7** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Provide at least 266 unduplicated patients with specialty care services over DY2	**Milestone 8** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 12 providers or facilities to provide specialty care services (over DY2) Data Source: Documentation of implemented contracts Milestone 8 Estimated Incentive Payment: $ 804,764 **Milestone 9** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Provide at least **400** unduplicated patients with

139485012.1.2	***1.9.2***	***1.9.2 (A-D)***	***IMPROVE ACCESS TO SPECIALTY CARE-***EXPAND SPECIALTY CARE SERVICES	
Baylor University Medical Center				*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.6*	*3.IT-11.1*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider-Asthma Improvement (Standalone measure)*	
	139485012.3.7	*3.IT-12.2*	*-Cervical Cancer Screening (Non-Standalone Measure)*	
	139485012.3.8	*3.IT-12.3*	*-Colorectal cancer screening (Non-Standalone Measure)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	implemented contracts Milestone 4 Estimated Incentive Payment: : $ 647,576 **Milestone 5** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Provide at least **133** unduplicated patients with specialty care services over DY2 Data Source: E.H.R Milestone 5 Estimated Incentive Payment: : $ 647,576	Data Source: E.H.R Milestone 7 Estimated Incentive Payment: $974,188	specialty care services over DY2 Data Source: E.H.R Milestone 9 Estimated Incentive Payment: $ 804,764
Year 2 Estimated Milestone Bundle Amount*:* $ 1,780,773	Year 3 Estimated Milestone Bundle Amount: $ 1,942,728	Year 4 Estimated Milestone Bundle Amount: $ 1,948,376	Year 5 Estimated Milestone Bundle Amount: $ 1,609,528
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $7,281,405			

Project Option 1.1.1 - Expand Pediatric Primary Care

Unique Project ID: 138910807.1.1
Performing Provider Name/TPI: Children's Medical Center/138910807

Provider: Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine. Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. Annually, Children's has approximately 600,000 patient contacts.

Children's has the largest market share for pediatrics in DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured). Children's is considered the safety net hospital for pediatrics in region.

MyChildren's payor mix is 75% Medicaid, 15% CHIP, 5% Self-pay (uninsured) and 5% Commercial insurance.

Intervention: Expand the capacity of pediatric primary care in Dallas County through 16 additional Children's Medical Center (CMC) primary care centers and a medical home for children with complex chronic illness, integrated with critical support services across a continuum of care to better accommodate the needs of the pediatric population (Medicaid and CHIP), so that children receive the right care at the right time, have access to same-day appointment thereby reducing the unnecessary use of Emergency Department services. This project will also establish pediatric urgent care services on the Dallas campus and implement telemedicine to connect school settings with pediatricians.

Need for the Project: Documented in the community needs (CN) assessment, specifically: CN. 3 Healthcare capacity, CN. 4: Primary Care and Pediatrics, CN 8: Chronic Disease, CN. 9: Specialty Care and CN. 12 Emergency Department Usage and Readmissions.

Target Population: Children covered by Medicaid or CHIP or are eligible for coverage who need primary care services including children with complex chronic health care needs, approximately 76,500 patients (volume DY5 + 10% attrition and new patients) and 529,100 visits. Estimated impact:

Type of volume	DY2	DY3	DY4	DY5
MyChildren's patients	21,500	35,000	51,800	69,000
MyChildren's visits	43,000	104,800	158,000	216,000
Complex chronic patients		150	300	400
Complex chronic visits		1,200	2,400	3,200
Telemedicine patients		-	100	150
Telemedicine visits		-	200	300

Total patients	21,500	35,150	52,200	69,550
Total visits	43,000	106,000	160,600	219,500

Category 1 & 2 Expected Patient Benefits: What is the project's benefit for Medicaid and Uninsured of your Service area? Children's Medical Center is the safety net hospital for children in Dallas County, providing the majority of ED, specialty and inpatient care to Medicaid and safety net patients/families. This project will increase in the number of children with all recommended well-child visits, increase in children receiving immunizations on schedule, increase in availability of same day or next day "sick" visits, reduce the inappropriate use of the emergency department and reduce overall cost of health care for children in Dallas County.

Category 3 Outcomes: OD-9 Preventive and Primary Care. IT-9.2 ED appropriate utilization (Stand-alone measure). This measure was selected because the project is designed to increase the availability of primary care for children covered by Medicaid and CHIP thereby reducing inappropriate utilization of ED services and improve the health of low-income children.

This project does not include any other federal grant money.

Project Description

This project is data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance (access to pediatric primary care).

Expand the capacity of pediatric primary care in Dallas County through sixteen additional Children's Medical Center (CMC) primary care centers and a medical home for children with complex chronic illness, integrated with critical support services across a continuum of care to better accommodate the needs of the pediatric population (Medicaid and CHIP), so that children receive the right care at the right time, have access to same-day appointments thereby reducing the unnecessary use of Emergency Department services. This project will also establish pediatric urgent care services on the Dallas campus and implement telemedicine to connect school settings with pediatricians. The additional capacity will be integrated with all other community-based providers across a continuum of care to establish a "virtual safety net" for children's health care.

Goals and Relationship to Regional Goals:

The goals of the project are to increase the availability of pediatric primary care services in Dallas County and ensure the appropriate use of such services by the population through support systems and electronic technology. Incremental increase in local pediatric primary care clinics with after-hours availability, coupled with a pediatric urgent care center and the use of telemedicine to link primary care providers with pediatric specialists will ensure both the availability and use of cost-effective, high-quality pediatric care and health advice and reduce unnecessary use of emergency department services.

This project is related to the regional goals of improving access to primary and preventive care, decreasing potentially avoidable admissions, decreasing potentially avoidable readmissions, decreasing potentially avoidable complications, increasing self-management skills, increasing adherence to self-care plans and increasing the availability of primary and preventive services.

Challenges

A major challenge will be to integrate the expanded primary care capacity with the existing pediatric continuum of care in the community: other primary care providers, urgent care services community health workers, faith-based programs, free clinics, homeless shelters, school systems, not-for-profit organizations, managed care payors, health departments and other to form a "virtual safety net" in the community. This project will address these challenges by coordinating with all providers in the Dallas County, establishing a regular forum for jointly addressing challenges and incrementally establishing the policies and linkages for a "virtual safety net" for the underserved children. A second major challenge will be changing the behaviors of families who have used emergency services for low complexity care. This challenge will be addressed through the use of health literacy principles, language and culturally appropriate approaches through the use of community health workers who reside in the community and understand the customs and speak the language. Behavior changes are projected based on the reduction in inappropriate emergency department utilization in a targeted zip code after a new MyChildren's primary care office opened in that zip code. A third challenge will be recruiting sufficient numbers of staff who are bilingual and multicultural. Children's is the pediatric training site for many student healthcare training programs. Bilingual and culturally diverse students will be identified through the relationships developed the training at Children's and then recruited after the student training is completed.

Five-Year Expected Outcomes for Provider and Patients:

The five-year expected outcomes of the project include increase in the number of children with all recommended well-child visits, increase in children receiving immunizations on schedule, increase in availability of same day or next day "sick" visits, reduce the inappropriate use of the emergency department and reduce overall cost of health care for children in Dallas County. Estimated impact: approximately 76,500 patients (volume DY5 + 10% attrition and new patients) and 529,100 visits.

Type of volume	DY2	DY3	DY4	DY5
MyChildren's patients	21,500	35,000	51,800	69,000
MyChildren's visits	43,000	104,800	158,000	216,000
Complex chronic patients		150	300	400
Complex chronic visits		1,200	2,400	3,200
Telemedicine patients		-	100	150
Telemedicine visits		-	200	300
Total patients	21,500	35,150	52,200	69,550
Total visits	43,000	106,000	160,600	219,500

Starting Point/Baseline

The baseline for this project is the number of MyChildren's locations in RHP 9 and the availability of telemedicine services in school settings at the beginning of DY1.

Rationale

Children's Medical Center's (CMC) emergency department (Dallas Campus) treats approximately 50,000 Level 4 and Level 5 visits annually (36% of total emergency department visits) for children with low-acuity illnesses and acute care symptoms, which can be more cost-effectively addressed in community-based primary care clinics. The days and times for the Level 4 and Level 5 visits include both normal workday hours, evening weekday hours and weekend hours. Children's Medical Center mapped the ZIP codes where the largest percentage of the families reside with children who were presenting themselves at the CMC emergency department for Level 4 and Level 5 visits. CMC then determined which of the identified ZIP codes lacked available and accessible primary care, located suitable lease opportunities in the identified ZIP codes for CMC primary care centers.

As concluded in the Regional Health Partnership IX Community Needs Assessment Report, Dallas Fort Worth Hospital Council, April 2012, the demand for pediatric primary care services, which are both accessible and convenient for patient families, exceeds the available capacity, thus limiting health care access for many low-level acute care management or chronic conditions. Emergency departments are treating high volumes of pediatric patients with preventable conditions or conditions that are suitable to be addressed in a primary care setting. Additionally, many pediatric primary care physicians accept a limited number of the Medicaid/CHIP/uninsured population and may have limited or no extended hours, ultimately even further restraining the capacity of many families to access important primary care services. Between 2000 and 2010, the percentage of Texas doctors accepting Medicaid patients decreased from 67% to 31%. In Dallas County, more than 68% of doctors said they would not take on children who use CHIP. Consequently, many families seek primary care treatment for their children in emergency care settings, resulting in increased health care costs and higher volumes of preventable and avoidable cases populating emergency department waiting rooms. Dallas County has significant Health Professional Shortage Areas (HPSA's) and Medically Underserved Areas (MUA's). Furthermore, in Dallas County, over 36.2% of children were enrolled in Medicaid in 2010, exacerbating the issue of availability of primary care access and treatment.

Approximately 500 pediatric patients at Children's Medical Center see five (5) or more pediatric specialists on a regular basis, and experience significant unnecessary utilization of emergency department inpatient and specialty care visits because of the lack of comprehensive primary care. Complex chronically ill children account for less than 5% of total patients in a pediatric population, but account for approximately 50% of the costs. Many primary care pediatricians do not feel comfortable treating children with complex chronic illnesses and therefore, refer

those children to the emergency department and pediatric specialists for virtually all of their acute care needs, unnecessarily overloading scarce pediatric emergency department services and pediatric specialty services at Children's Medical Center / UT Southwestern. Additionally, without access to comprehensive primary care, children with complex chronic illnesses lack access to appropriate preventive care services. The establishment of a medical home for children with complex chronic illness, as part of the expansion of pediatric primary care capacity in Dallas, coupled with the use of telemedicine capability, will provide children with complex chronic illness with primary care, care coordination and preventive care. This will reduce unnecessary emergency visits, unnecessary specialty visits and unnecessary readmissions.

Telemedicine services will begin with a pilot at Mi Escuelita. Mi Escuelita is a preschool system in Dallas targeting preschoolers with limited English proficiency (LEP) and living at or near the poverty level. The goal is prepare these children to be successful in school once they reach primary school age and to teach their families how to support these children to be successful in school. There are two locations in Dallas in medically underserved areas. Telemedicine will be used to connect a school nurse to pediatric primary care provider to bring pediatric primary care services to the preschool setting. After the pilot, telemedicine services will expand to public school settings.

Project Components:

Project 1.1.1 "Establish more primary care clinics" does not contain core project components.

Milestones and Metrics:

Milestones and metrics are based on relevancy to the RHP 9's pediatric population, the community needs for additional pediatric primary care, the RHP priority rating of this project in the highest priority (A) category and the baseline data of non-emergent emergency department use by children.

Community Needs (CN) Addressed:

- CN 3: Healthcare Capacity
- CN 4: Primary Care and Pediatrics
- CN 8: Chronic Disease
- CN 9: Specialty Care
- CN 11: Emergency Department Usage and Readmissions

How the Project significantly enhances an existing delivery system reform initiative:

The project will significantly enhance the current supply of pediatric primary care and lessen the burden of care in current Federally Qualified Healthcare Centers and Parkland's Community

Oriented Primary Care Centers (COPCs). This project is based on the inappropriate emergency department use by children in Dallas County.

Related Category 3 Outcome Measure and Reason for Selecting Outcomes Measure

OD-9 Preventive and Primary Care. IT-9.2 ED appropriate utilization. (Stand-alone measure) This measure was selected because the project is designed to support appropriate utilization of ED services and improve the health of low-income children by significantly increasing the number of primary care providers who accept Medicaid and CHIP. Locations of the providers will be based on medically underserved areas, zip codes with high usage ED services for primary care and inadequate supply of pediatric primary care providers in the area. Telemedicine use will be piloted to determine if it is an additional methodology to bring health care services to locations where children need care.

Relationship to other projects

138910807.1.2 Expand Primary Care Hours
138910807.1.3 Implement Disease Management
138910807.1.4 Expand Pediatric Behavioral Health
138910807.2.1 Expand/Enhance Medical Homes
138910807.2.2 Implement/Enhance Evidence-based Health Promotion Programs
138910807.2.3 Expand/Enhance Patient/Family Navigation
138910807.2.4 Implement/Expand Care Transitions Program
RD-1 Potentially Preventable Admissions
RD-2 30-day readmissions
RD-3 Potentially Preventable Complications
RD-6 Initial Core Set of Health Care Quality Indicators

This project is related to the other Catgegory 1 and 2 projects proposed by Children's because four of the other projects (Expand Primary care Hours, Implement Disease Management, Expand Pediatric Behavioral Health and Expand/Enhance Medical Homes) are all focused within the MyChildren's practices. The remaining three projects support overall population health and are supportive of this project to expand the number of primary care clinics.

Relationship to Other Performing Providers' Projects in the RHP

Other projects that focus on expanding primary care are:

Performing Provider	Unique Project ID
Baylor Medical Center at Garland	121790303.1.1
Baylor Medical Center at Irving	121776204.1.1
Baylor Medical Center at Carrollton (Trinity)	195018001.1.1
Baylor University Medical Center	139485012.1.1
Medical City Dallas (HCA)	020943901.1.3
Parkland Health & Hospital System	127295703.1.1

Parkland Health & Hospital System	127295703.1.2
Parkland Health & Hospital System	127295703.1.6
Texas Health Presbyterian – Dallas	020908201.1.1
UT Southwestern Medical Center Faculty Plan	126686802.1.1
UT Southwestern Medical Center Faculty Plan	126686802.1.2

We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

This project was valued using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	9	1.80
Population Served / Project Size	25%	8	2.00
Alignment with Community Needs	20%	9	1.80
Cost Avoidance	15%	8	1.20
Sustainability	15%	8	1.20
Partnership Collaboration	5%	8	0.40
	100%		8.40

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact

Moderate Weakness: Lessens impact

Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

No other federal grant dollars are being used for this project.

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138910807.1.1	***1.1.1***	***NO COMPONENTS***	***EXPAND PEDIATRIC PRIMARY CARE***	
Children's Medical Center of Dallas				*138910807*
Related Category 3 Outcome Measure(s):	*138910807.3.1*	*IT-9.2*	*ED appropriate utilization (Stand-alone measure)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): 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. d. Seven (7) additional clinics by 9/30/13 16,700 patients and 33,400 visits Milestone 1 Estimated Incentive	Milestone 3 (P-1): 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. d. Goal: Two(2) additional clinics including complex chronic care and clinic with urgent care capacity by 9/30/14 32,150 patients and 96,200 visits Milestone 3 Estimated Incentive Payment $ 1,726,279	Milestone 5 (I-12): Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.2. Metric: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. a. Total number of unique patients encountered in the clinic for reporting period. b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care. Goal: 20% new patients increase from DY3: 38,400 total patients, 6,400 incremental new patients Milestone 5 Estimated Incentive Payment*:* $3,447,206	Milestone 6 (I-12): Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.2. Metric: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. a. Total number of unique patients encountered in the clinic for reporting period. b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care. d. Goal: 20% increase from DY4 46,800 total patients, 7,680 incremental new patients Milestone 6 Estimated Incentive $ 2,783,458

138910807.1.1	***1.1.1***	***NO COMPONENTS***	***EXPAND PEDIATRIC PRIMARY CARE***
Children's Medical Center of Dallas			*138910807*
Related Category 3 Outcome Measure(s):	*138910807.3.1*	*IT-9.2*	*ED appropriate utilization (Stand-alone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Payment *(maximum amount):* $1,687,860 Milestone 2 (P-5): Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers P-5.1. Metric: Documentation of increased number of providers and staff and/or clinic sites. a. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation b. Rationale: Additional staff members and providers may be necessary to increase capacity to deliver care. C. Goal: 25 number of new staff with training completed by 9/30/13 Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,687,860	Milestone 4 (P-5): Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers P-5.1. Metric: Documentation of increased number of providers and staff and/or clinic sites. a. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other documentation b. Rationale: Additional staff members and providers may be necessary to increase capacity to deliver care. C. Goal: 15 new staff with training completed by 9/30/14 Milestone 4 Estimated Incentive Payment *(maximum amount):* $ 1,726,279		
Year 2 Estimated Milestone Bundle Amount $3,375,720	Year 3 Estimated Milestone Bundle Amount: $3,452,558	Year 4 Estimated Milestone Bundle Amount: $3,447,206	Year 5 Estimated Milestone Bundle Amount: $2,783,458
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $13,058,942			

Project Option 1.1.2 - Expand Pediatric Primary Care Hours

Unique Project ID: 138910807.1.2
Performing Provider Name/TPI: Children's Medical Center/138910807

Provider: Size of provider system and service area: Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine. Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP.

Provider's role in region's health care infrastructure: Children's has the largest market share for pediatrics in DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured).

MyChildren's payor mix is 75% Medicaid, 15% CHIP, 5% Uninsured and 5% Commercial insurance.

Intervention: The purpose of this project is to expand the hours of operation to include nights and weekends at the MyChildren's locations and to establish a 24 hour RN triage telephone service. It is an expansion of an existing initiative.

Need for the Project: The need for this project is documented in the community needs (CN) assessment, specifically: CN. 3 Healthcare capacity, CN. 4: Primary Care and Pediatrics, CN 8: Chronic Disease, CN. 9: Specialty Care and CN. 12 Emergency Department Usage and Readmissions.

Target Population: Children covered by Medicaid, CHIP or uninsured: approximately 86,000 patients (95% of total patients)

Intervention	DY2	DY3	DY4	DY5
Patients on panel	39,000	50,600	71,000	90,500
Extended hours visits	1,800	12,000	23,000	29,000
RN triage calls	7,000	10,500	15,000	20,000

Category 1 & 2 Expected Benefit: Provide access to primary care in the appropriate setting on nights and weekends.

Category 3 Outcome: OD-9 Preventive and Primary Care. IT-3.9.2 ED appropriate utilization. (Stand alone measure) This measure was selected because the project is designed to support appropriate utilization of ED services and reduce the inappropriate use of ED services.

The project will not use additional federal grant dollars.

Project Description

This project is data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance (inadequate access to pediatric primary care).

Expand the capacity of pediatric primary care in Dallas County through (B) expanding primary clinic hours and (C) expanding primary care clinic staffing to better accommodate the needs of the pediatric population (Medicaid and CHIP), so that children receive the right care at the right time; have access to same-day appointment thereby reducing the unnecessary use of Emergency Department services. No additional primary care clinic space (component A) is anticipated as additional capacity can be achieved in the current space by increasing hours open and adding staff. This project will also establish a 24/7 pediatric nurse/physician advice line and outreach call capability. The additional capacity will be integrated with all other community-based providers across a continuum of care to establish a "virtual safety net" for children's health care.

Goals and Relationship to Regional Goals:

The goals of the project are to increase the availability of pediatric primary care services in Dallas County and ensure the appropriate use of such services by the population through support systems and electronic technology. Incremental increase in local pediatric primary care clinics with after-hours availability, coupled with a 24/7 pediatric nurse/physician advice line and outreach call capability will ensure both the availability and use of cost-effective, high-quality pediatric care and health advice and reduce unnecessary use of emergency department services.

This project is related to the regional goals of improving access to primary and preventive care, decreasing potentially avoidable admissions, decreasing potentially avoidable readmissions, decreasing potentially avoidable complications, increasing self-management skills, increasing adherence to self-care plans and increasing the availability of primary and preventive services.

Challenges

A major challenge will be to integrate the expanded primary care capacity with the existing pediatric continuum of care in the community: other primary care providers, urgent care services community health workers, faith-based programs, free clinics, homeless shelters, school systems, not-for-profit organizations, 24/7 pediatric call center, managed care payors, health departments and other to form a "virtual safety net" in the community. This project will address these challenges by coordinating with all providers in the Dallas County, establishing a regular forum for jointly addressing challenges and incrementally establishing the policies and linkages for a "virtual safety net" for the underserved children. A second major challenge will be changing the behaviors of families who have used emergency services for low complexity care. This challenge will be addressed through the use of health literacy principles, language

and culturally appropriate approaches the through the use of community health workers who reside in the community and understand the customs and speak the language. Behavior changes are projected based on the reduction in inappropriate emergency department utilization in a targeted zip code after a new MyChildren's primary care office opened in that zip code. A third challenge will be recruiting sufficient numbers of staff who are bilingual and multicultural. Children's is the pediatric training site for many student healthcare training programs. Bilingual and culturally diverse students will be identified through the relationships developed the training at Children's and then recruited after the student training is completed.

Five-year Expected Outcomes for Provider and Patient:

The five-year expected outcomes of the project include increase in the number of children with all recommended well-child visits, increase in children receiving immunizations on schedule, increase in availability of same day or next day "sick" visits, reduction in the inappropriate emergency department use and reduction in overall cost of health care for children in Dallas County.

Starting point/baseline

The baseline for this project is the hours of operations of MyChildren's locations in Dallas County at the beginning on DY1.

Rationale

Children's Medical Center's (CMC) emergency department (Dallas Campus) treats approximately 50,000 Level 4 and Level 5 visits annually (36% of total emergency department visits) for children with low-acuity illnesses and acute care symptoms, which can be addressed in more cost-effective manner in community-based primary care clinics. The days and times for the Level 4 and Level 5 visits include both normal workday hours, evening weekday hours and weekend hours. Children's Medical Center mapped the ZIP codes where the largest percentage of the families reside with children who were presenting themselves at the CMC emergency department for Level 4 and Level 5 visits. CMC then determined which of the identified ZIP codes lacked available and accessible primary care, located suitable lease opportunities in the identified ZIP codes for CMC primary care centers.

As concluded in the Regional Health Partnership IX Community Needs Assessment Report, Dallas Fort Worth Hospital Council, April 2012, the demand for pediatric primary care services, which are both accessible and convenient for patient families, exceeds the available capacity, thus limiting health care access for many low-level acute care management or chronic conditions. Emergency departments are treating high volumes of pediatric patients with preventable conditions or conditions that are suitable to be addressed in a primary care setting. Additionally, many pediatric primary care physicians accept a limited number of the Medicaid/CHIP/uninsured population and may have limited or no extended hours, ultimately even further restraining the capacity of many families to access important primary care

services. Between 2000 and 2010, the percentage of Texas doctors accepting Medicaid patients decreased from 67% to 31%. In Dallas County, more than 68% of doctors said they would not take on children who use CHIP. Consequently, many families seek primary care treatment for their children in emergency care settings, resulting in increased health care costs and higher volumes of preventable and avoidable cases populating emergency department waiting rooms. Dallas County has significant Health Professional Shortage Areas (HPSA's) and Medically Underserved Areas (MUA's). Furthermore, in Dallas County, over 36.2% of children were enrolled in Medicaid in 2010, exacerbating the issue of availability of primary care access and treatment.

Target Population: Children covered by Medicaid, CHIP or uninsured: approximately 86,000 patients (95% of total patients)

Intervention	DY2	DY3	DY4	DY5
Patients on panel	39,000	50,600	71,000	90,500
Extended hours visits	1,800	12,000	23,000	29,000
RN triage calls	7,000	10,500	15,000	20,000

Project Components and How Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative

Project 1.1.2 "Establish more primary care clinics" does contain core project components. As noted above, we will not be using component (A), expand clinic space but will increase capacity through components (B) expand clinic hours and (C) expand primary care staffing. Milestones and metrics are based on relevancy to the RHP 9"s pediatric population, the community needs for additional pediatric primary care, the RHP priority rating of this project in the highest priority (A) category and the baseline data of non-emergent emergency department use by children.

The project will enhance the current supply of pediatric primary care and lessen the burden of care in current Federally Qualified Healthcare Centers and Parkland's Community Oriented Primary Care Centers (COPCs). This project is based on the inappropriate emergency department use by children in Dallas County.

Community Needs (CN) Addressed:

- CN 3: Healthcare Capacity
- CN 4: Primary Care and Pediatrics
- CN 8: Chronic Disease, CN 9: Specialty Care
- CN 11: Emergency Department Usage and Readmissions

Related Category 3 Outcome Measure(s)

OD-9 Preventive and Primary Care. IT-9.2 ED appropriate utilization. (Stand alone measure)

This measure was selected because the project is designed to support appropriate utilization of ED services and improve the health of low-income children. By providing additional hours of access will have better access to primary care services which can reduce inappropriate ED utilization. Use of a nurse triage telephone system can redirect families to more appropriate levels of care, thereby reducing inappropriate ED utilization. Use of the nurse triage telephone system can also direct families to seek care in an urgent care setting or emergency department setting when that level of medical care is indicated.

Relationship to other projects:

138910807.1.1 Expand Pediatric Primary Care
138910807.1.3 Implement Disease Management
138910807.1.4 Expand Pediatric Behavioral Health
138910807.2.1 Expand/Enhance Medical Homes
138910807.2.2 Implement/Enhance Evidence-based Health Promotion Programs
138910807.2.3 Expand/Enhance Patient/Family Navigation
138910807.2.4 Implement/Expand Care Transitions Program
RD-1 Potentially Preventable Admissions
RD-2 30-day readmissions
RD-3 Potentially Preventable Complications
RD-6 Initial Core Set of Health Care Quality Indicators

This project is related to the other Catgegory 1 and 2 projects proposed by children's because four of the other projects (Expand Pediatric Primary Care, Implement Disease Management, Expand Pediatric Behvaioral Health and Expand/Enhance Medical Homes are all focused within the MyChildren's practices. The remaining three projects support overall population health and are supportive of this project to expand the hours of operation in primary care clinics.

Relationship to Other Performing Providers' Projects in the RHP:
Other projects that focus on expanding primary care are:

Performing Provider	Unique Project ID
Baylor Medical Center at Garland	121790303.1.1
Baylor Medical Center at Irving	121776204.1.1
Baylor Medical Center at Carrollton (Trinity)	195018001.1.1
Baylor University Medical Center	139485012.1.1
Medical City Dallas (HCA)	020943901.1.3
Parkland Health & Hospital System	127295703.1.1
Parkland Health & Hospital System	127295703.1.2
Parkland Health & Hospital System	127295703.1.6
Texas Health Presbyterian – Dallas	020908201.1.1
UT Southwestern Medical Center Faculty Plan	126686802.1.1
UT Southwestern Medical Center Faculty Plan	126686802.1.2

We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

This project was valued using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	9	1.80
Population Served / Project Size	25%	5	1.25
Alignment with Community Needs	20%	9	1.80
Cost Avoidance	15%	8	1.20
Sustainability	15%	8	1.20
Partnership Collaboration	5%	8	0.40
	100%		7.65

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact

Moderate Weakness: Lessens impact

Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on

HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

The project will not use additional federal grant dollars.

References

1. Halfon N, Newacheck PW, Wood DL, St Peter, RF. Routine emergency department use for sick child care by children in the United States . *Pediatrics.* 1996; 98: 28-34
2. Smith-Campbell B. Emergency department and community health center visits and costs in an uninsured population. *Journal of Nursing Scholarship.* 2005*;* 37(1): 80-86
3. Cooley WC, McAllister JW, Sherrieb K, Kuhlthau K. Improved Outcomes with Medical Home Implementation in Pediatric Primary Care. *Pediatrics.* 2009; 124: 358-364
4. Flores G. The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review *Medical Care Resources Review.* June 2005; 62: 255-299
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7. Bunik M, et al. Pediatric telephone call centers: how do they affect health care use and costs? *Pediatrics* (2007); e305 – e313.
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11. http://www.ahrq.gov/cahps/clinician_group/
12. http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/issue_papers/callcentermetricspaperbestpr.pdf

138910807.1.2	***1.1.2***	***COMPONENTS B AND C***	***EXPAND PEDIATRIC PRIMARY CARE HOURS***	
Children's Medical Center of Dallas				*138910807*
Related Category 3 Outcome Measure(s):	*138910807.3.2*	*IT-9.2*	*ED appropriate utilization (Stand-alone 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-4): Expand the hours of a primary care clinic, including evening and/or weekend hours P-4.1. Metric: Increased number of hours at primary care clinic over baseline a. Data Source: Clinic documentation b. Rationale/Evidence: Expanded hours not only allow for more patients to be seen, but also provide more choice for patients. C. Goal: 1,500 visits for after hours care available; 34,300 patients with access to after hours care Completed by 9/30/13 Milestone 1 P4 Estimated Incentive Payment *(maximum amount):* $ 1,558,025 Milestone 2 (P-5): Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers P-5.1. Metric: Documentation of increased number of providers and staff and/or clinic sites. a. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report, policy, contract or other	Milestone 3 (P-7): Establish a nurse advice line. P-7.1. Metric: Documentation of nurse advice line. a. Data Source: Documentation of advice line, operating hours and triage policies. Advise line system logs and triage algorithms**.** b. Rationale: In many cases patients are unaware of the appropriate location and timing to seek care for urgent and chronic conditions. Implementation of a nurse advice line allows for primary care to be the first point of contact and offer clinical guidance around how to mitigate symptoms, enhance patient knowledge about certain conditions and seek timely care services. c. Goal: RN Advice Line implemented by 9/30/14, 50,500 patients with access to RN Advice Line Milestone 3 P7 Estimated Incentive Payment *(maximum amount):* $ 3,186,977	Milestone 4 (I-14): Increase the number of patients served and questions addressed on the nurse advice line. Demonstrate improvement over prior reporting period. I-14.1. Metric: Number of patients served by the nurse advice line. Demonstrate improvement over baseline rates. a. Numerator: number of unique records created from calls received to the nurse advice line. b. Denominator: total number of calls placed to the nurse advice line (distinct from number of calls answered). c. Data Source: Automated data from call center d. Rationale/Evidence: This measure will indicate how many calls are addressed successfully as well as an overall call abandonment rate. Abandonment rate is the percentage of calls coming into a telephone system that are terminated by the person originating the call before being answered by a staff person. It is related to the management of emergency calls. This metric speaks	Milestone 5 (I -14): Increase the number of patients served and questions addressed on the nurse advice line. Demonstrate improvement over prior reporting period. I-14.1. Metric: Number of patients served by the nurse advice line. Demonstrate improvement over baseline rates. a. Numerator: number of unique records created from calls received to the nurse advice line. b. Denominator: total number of calls placed to the nurse advice line (distinct from number of calls answered). c. Data Source: Automated data from call center d. Rationale/Evidence: This measure will indicate how many calls are addressed successfully as well as an overall call abandonment rate. Abandonment rate is the percentage of calls coming into a telephone system that are terminated by the person originating the call before being answered by a staff person. It is related to the management of emergency calls. This metric speaks to the capacity of the nurse advice line. e. Goal: 9,500 calls by 09/30/16 Milestone 5 I-14 Estimated Incentive

138910807.1.2	***1.1.2***	***COMPONENTS B AND C***	***EXPAND PEDIATRIC PRIMARY CARE HOURS***	
Children's Medical Center of Dallas				*138910807*
Related Category 3 Outcome Measure(s):	*138910807.3.2*	*IT-9.2*	*ED appropriate utilization (Stand-alone 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)**
documentation b. Rationale: Additional staff members and providers may be necessary to increase capacity to deliver care. c. Goal: 2 new staff trained by 9/30/13 Milestone 2 P5 Estimated Incentive Payment *(maximum amount):* $ 1,558,024			to the capacity of the nurse advice line. e. Goal: 7,100 calls by 9/30/16 Milestone 4 (I-14): Estimated Incentive Payment *(maximum amount):* $ 3,182,036	Payment *(maximum amount):* $ 2,569,346
Year 2 Estimated Milestone Bundle Amount: $ 3,116,049	Year 3 Estimated Milestone Bundle Amount: $ 3,186,977		Year 4 Estimated Milestone Bundle Amount: $ 3,182,036	Year 5 Estimated Milestone Bundle Amount: $2,569,346
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 12,054,408				

Project Option 1.3.1 – Implement/Utilize Pediatric-Specific Disease Management System Functionality

Unique Project ID: 138910807.1.3
Performing Provider Name/TPI: Children's Medical Center/138910807

Provider: Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine. Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. Provider's role in region's health care infrastructure (especially for Medicaid and indigent/uninsured): Children's has the largest market share for pediatrics in DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured).

MyChildren's payor mix is 75% Medicaid, 15% CHIP, 5% uninsured and 5% commercial insurance.

Intervention: The purpose of this project is to implement a disease management program at the MyChildren's location and in school-based primary care settings in RHP 9. It is a new initiative.

Need for the Project: The need for this project is documented in the community needs (CN) assessment, specifically CN. 3 Healthcare capacity, CN. 4: Primary Care and Pediatrics, CN 8: Chronic Disease, CN. 9: Specialty Care and CN. 12 Emergency Department Usage and Readmissions

Target Population: Children in RHP 9 covered by Medicaid and CHIP or uninsured who use MyChildren's as their primary care provider and who have chronic diseases. Estimated number of patients covered by CHIP, Medicaid or uninsured to be served over course of waiver period 8,800 (10% increase due to attrition and new patients, 95% of volume to account for commercially insured population, plus rounding.)

This project will benefit the targeted population by providing disease management to children with chronic diseases resulting in the best management of chronic disease with the least cost and minimal disruption of daily life for these children and their families.

Intervention	DY3	DY4	DY5
Disease management patients	5,300	7,100	9,000
Disease management contacts	15,900	28,400	45,000

It is estimated that 95% of the above patient population will be in the targeted patient population based on the current MyChildren's payor mix.

Category 1 & 2 Expected Outcomes: Process and improvement milestones were selected to support the successful implementation of the project.

Category 3 Outcome: OD-9 Preventive and Primary Care. IT-3.9.3 Pediatric/Young Adult Asthma Emergency Department Visits. (Stand alone measure) This measure was selected because the project is designed to support appropriate management of asthma and reduce the use of ED services for asthma management.

No additional federal grant dollars are being applied to this project.

Project Description

Children's Medical Center (CMC) has seven (7) Joint Commission Disease-Specific Certified disease management programs and will expand their availability into medical home settings through the MyChildren's network of practices in Dallas and Denton County. This project is data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance (chronic disease management).

Goals and Relationship to Regional Goals

The goal of this project is to expand the CMC-certified disease management programs capacity to treat more patients and to provide the infrastructure and support needed to accomplish standardized, evidence-based chronic illness management in the primary care setting and implement the infrastructure that supports patient population health, panel management and coordination of care. In order to do this, we propose to:

- Expand the CMC certified disease management programs in community ambulatory settings
- Design care coordination strategies that optimize care across a continuum, including home, school and community settings
- Design culturally appropriate patient/family self-management programs for chronic illness management
- Incorporate electronic registries, predictive modeling, decision support and social awareness systems that are pediatric-specific and family focused into team-based practice settings
- Incorporate and maintain evidence-based standards in the pediatric disease management programs
- Design and implement pediatric community-based resource centers for joint patient/family education and behavior change programs, opportunities for patients/families to learn from each other and the creation of support networks for providers, patients and families

Challenges

A major challenge will be changing patient/family behaviors to improve and maintain the health of children with chronic illnesses. Training patients/families in self-management of their own health is a challenge for any population of chronically ill patients. Another challenge will be the ability to risk-adjust the population and tailor the interventions to achieve the best outcomes with limited resources. These challenges will be addressed by using behavior change science, health literacy principles, language and culturally appropriate approaches and the use of community health workers who reside in the community, understand the customs and speak the language. State-of-the-art, evidence-based software will be used for risk-adjusting the population and identifying the children who are appropriate for enrollment in disease management programs and identifying the children who are at highest risk. Challenges of this project will also be addressed by reaching out to other providers and using collaborative learning to address similar challenges or use lessons learned from others to address unique challenges.

Five-year Expected Outcome for Provider and Patients

Implementing and utilizing pediatric-specific disease management system functionality is a prerequisite for many of the improvements targeted by pediatric medical home initiatives to prevent disease, minimize unnecessary exacerbation of chronic illness, train patients/families in effective behavior change and self-management techniques and maintain a higher state of well-being across the family. Additionally, pediatric-specific disease management programs that are electronically supported and integrated consistently across the continuum of care can keep children out of the emergency department, specialist clinics and inpatient beds. The expected result will be decreased ED visits, decreased specialty clinic visits and decreased preventable admissions/ readmissions/ complications (PPAs, PPRs and PPCs).

Starting point/baseline

Baseline will be number of patients enrolled in program during DY1.

Rationale

Effective and accessible pediatric-specific chronic disease management programs have been shown to have a measurable impact on quality of life, reducing the risk and consequences of worsening health conditions, reducing the need for unnecessary ED visits, specialist visits and inpatient admissions/length of stay (LOS).

According to Regional Health Partnership IX Community Needs Assessment Report, Dallas Fort Worth Hospital Council, April 2012, between 2000 and 2010, the number of Children's Medical Center's admissions of youth with a primary or secondary diagnosis of diabetes increased by 34%. Additionally, the racial disparity of higher diabetic-related deaths in African Americans

demonstrated in the adult population is also present among children. According to the Dallas Morning News, "those of Mexican ancestry, for example, are nearly twice as likely to have diabetes as non-Hispanic whites." With the association of diabetes and obesity there is also concern of the future trajectory as low income preschool obesity within the Dallas Metropolitan Statistical Area was 17.2% in 2009, placing many young children at higher risk of developing diabetes in later years. Finally, the Community Needs Assessment Report documented increasing rates of many chronic diseases, including but not limited to asthma and diabetes.

According to Children's Medical Center data, between 2000 and 2010, the number of Children's Medical Center admissions of youth with a primary or secondary diagnosis of asthma increased 15%.

Intervention	DY3	DY4	DY5
Disease management patients	5,300	7,100	9,000
Disease management contacts	15,900	28,400	45,000

It is estimated that 95% of the above patient population will be in the targeted patient population based on the current MyChildren's payor mix.

Project components

All project components will be addressed during this project implementation.

a. Enter patient data into unique chronic disease registry
b. Use registry data to proactively identify, contact, educate and track patients by disease status, risk status, self-management status, self-management status, community and family need
c. Use registry to develop and implement targeted QI plan
d. Conduct quality improvement or 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 the expansion of the project, including special considerations for safety-net populations.

Community Needs (CN) Addressed:

- CN 3: Healthcare Capacity
- CN 4: Primary Care and Pediatrics,
- CN 8: Chronic Disease
- CN 9: Specialty Care
- CN 11: Emergency Department Usage and Readmissions

How the Project Significantly Enhances an Existing Delivery System

Children's Medical Center (CMC) has seven (7) Joint Commission Disease-Specific Certified disease management programs, however, resources, infrastructure and technology have been severely limited, and therefore, CMC is only able to care for a very small percentage (<1%) of chronic disease management patients in Dallas County. By expanding the programs into the MyChildren's practices in RHP9, a significant increase in the number of patients is achievable.

Related Category 3 Outcome Measure and Rationale for Selecting Outcome Measure

IT 2.13 Other Admission Rates: Pediatric Quality Indicator PDI #14 Asthma Admission Rate (Standalone measure). This is a provider-defined measure. This measure is based on IT 2-12 Prevention Quality Indicator (PQI) Composite Measures for Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions which are adult-based measures. The Pediatric Quality Indicator PDI #14 will be used for the data definition for the numerator in the outcome measure. PDI #14 was selected because asthma management will be a major component of the disease management program. Past history with Children's limited implementation of an asthma management program demonstrated reduced hospital admissions in the patients enrolled in the program.

Relationship to other projects

138910807.1.1	Expand Pediatric Primary Care
138910807.1.2	Expand Pediatric Primary care Hours
138910807.1.4	Expand Pediatric Behavioral Health
138910807.2.1	Expand/Enhance Medical Homes
138910807.2.2	Implement/Enhance Evidence-based Health Promotion Programs
138910807.2.3	Expand/Enhance Patient/Family Navigation
138910807.2.4	Implement/Expand Care Transitions Program
RD-1	Potentially Preventable Admissions
RD-2	30-day readmissions
RD-3	Potentially Preventable Complications
RD-6	Initial Core Set of Health Care Quality Indicators

This project is related to the other Catgegory 1 and 2 projects proposed by Children's because four of the other projects (Expand Pediatric Primary Care, Expand Pediatric Primary Care Hours, Expand Pediatric Behvaioral Health and Expand/Enhance Medical Homes are all focused within the MyChildren's practices. The remaining three projects support overall population health and are supportive of this project to enhance diseasement capabilities.

Relationship to Other Performing Providers' Projects and the Plan for Learning Collaborative
Other projects that focus on chronic disease/registry include:

Performing Provider	Unique Project ID
Baylor Medical Center at Garland	121790303.2.2
Baylor Medical Center at Irving	121776204.2.2
Baylor Medical Center at Carrollton (Trinity)	195018001.2.1
Baylor University Medical Center	139485012.2.2
Denton County Health & Human Services	136360803.2.1
Methodist Charlton Medical Center	126679303.2.1
Methodist Dallas Medical Center	135032405.2.2
Methodist Richardson Medical Center	209345201.2.1
Parkland Health & Hospital System	127295703.1.3
Parkland Health & Hospital System	127295703.2.4
Texas Health Presbyterian – Denton	020967801.2.2
Texas Health Presbyterian – Kaufman	094140302.2.2
UT Southwestern Medical Center Faculty Plan	126686802.2.2

We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

This project was valued using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	7	1.40
Population Served / Project Size	25%	6	1.50
Alignment with Community Needs	20%	9	1.80
Cost Avoidance	15%	6	0.90
Sustainability	15%	8	1.20
Partnership Collaboration	5%	9	0.45
	100%		7.25

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness

	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact
Moderate Weakness: Lessens impact
Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

The project will not use additional federal grant dollars.

References

1. Goetz RZ, Ozminkowski RJ, Villagra VG, Duffy J. Return on investment in disease management: a review. *HealthCare Financing Review,* 2005; 26: 1-19
2. Joni K. Beck, PharmD, CDE, Kathy J. Logan, RN, MS, RD/LD, CDE, Robert M. Hamm, PhD, Scott M. Sproat, MHA, Kathleen M. Musser, MD, Patricia D. Everhart, Harrold M. McDermott, MBA, CPA, Kenneth C. Copeland, MD. Reimbursement for Pediatric Diabetes Intensive Case Management: A Model for Chronic Diseases? *Pediatrics* Vol. 113 No. 1 January 1, 2004 pp. e47 -e50.
3. Tracy A Lieu, Charles P Quesenberry, Michael E Sorel, Guillermo R Mendoza and Albin B Leong. Prediction Models to Support Cost-Effective Disease Management of Pediatric Asthma. *Pediatric Research* (1997) 41, 78–78; doi:10.1203/00006450-199704001-00471
4. Smith, JL. A Roadmap to the Disease Specific Care Certification Process. Orthopaedic Nursing, 2008; 27: 218-222
5. By focusing on managing chronic conditions in a safety net population, hospitalizations will reduce and overall quality of life will increase while reducing overall costs to the health care system.

138910807.1.3	*1.3.1*	*1.3.1 A, B, C, D*	**Implement and Utilize Pediatric-Specific Disease Management System Functionality**	
Children's Medical Center				138910807
Related Category 3 Outcome Measure(s):	*138910807.3.3*	*IT-9.3*	*Pediatric and Young Adult Asthma Emergency Visits – NQF 1381*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-2): Review current registry capability and assess future needs. P-2.1. Metric: Documentation of review of current registry capability and assessment of future registry needs. a. Numerator: number entered into the registry;0 if documentation is not provided, 1 if it is provided; b. Denominator: total patients with the target condition; c. Data source: EHR systems and/or other performing provider documentation. d. Rationale/Evidence: Used to determine if the necessary elements for a chronic disease registry are in place for optimal care management. Necessary elements may include inpatient admissions, emergency department visits, test results, medications, weight, activity level changes and/or diet changes. e. Goal: Complete by 9/30/12 Milestone 1 P-2 Estimated Incentive Payment *(maximum amount):* $3,116,049	Milestone 2 (P-4): Implement/expand a functional disease management registry. P-4.1. Metric: Registry functionality is available in 50% of the Performing Provider's sites and includes an expanded number of targeted diseases or clinical conditions. a. Numerator: Number of sites with registry functionality b. Denominator: Total number of sites c. Data Source: Documentation of adoption, installation, upgrade, interface or similar documentation d. Rationale/Evidence: Utilization of registry functionalities helps care teams to actively manage patients with targeted chronic conditions because the disease management registry will include clinician prompts and reminders, which should improve rates of preventive care. Having the functionality in as many sites as possible will enable care coordination for patients as they access various services throughout a Performing Provider's facilities. Registry use can be targeted to clinical conditions/diseases most pertinent to the patient population (e.g., diabetes, hypertension, chronic heart failure). e. Goal: 50% of sites (7 sites) with disease registry implemented by 9-30-14	Milestone 4 (I-16): Increase the number of patient contacts recorded in the registry relative to baseline rate. I-16.1. Metric: Total number of in-person and virtual (including email, phone and web based) visits, either absolute or divided by denominator. a. Numerator: Number of patient contacts recorded in the registry b. Denominator: Number of targeted patients in the registry ("targeted" as defined by Performing Provider) c. Data source: Internal clinic or hospital records/documentation d. Rationale/evidence: help physicians and other members of a patient's care team identify and reach out to patients who may have gaps in their care. Goal: Average 2 contacts per eligible patient, 14,200 contacts by 9/30/2015 Milestone 4 I-16 Estimated Incentive Payment *(maximum amount):* $1,591,018 Milestone 5 (I-17): Use the registry	Milestone 6 (I-16): Increase the number of patient contacts recorded in the registry relative to baseline rate. I-16.1. Metric: Total number of in-person and virtual (including email, phone and web based) visits, either absolute or divided by denominator. a. Numerator: Number of patient contacts recorded in the registry b. Denominator: Number of targeted patients in the registry ("targeted" as defined by Performing Provider) c. Data source: Internal clinic or hospital records/documentation d. Rationale/evidence: help physicians and other members of a patient's care team identify and reach out to patients who may have gaps in their care. Goal: Average 3 contacts per eligible patient, 27,000 contacts by 9/30/2016 Milestone 6: I-16 Estimated Incentive Payment *(maximum amount):* $ $2,569,346

138910807.1.3	*1.3.1*	*1.3.1 A, B, C, D*	**Implement and Utilize Pediatric-Specific Disease Management System Functionality**	
Children's Medical Center				138910807
Related Category 3 Outcome Measure(s):	*138910807.3.3*	*IT-9.3*	*Pediatric and Young Adult Asthma Emergency Visits – NQF 1381*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 2 P-4 Estimated Incentive Payment *(maximum amount):* $1,593,489 Milestone 3 (P-5): Demonstrate registry automated reporting ability to track and report on patient demographics, diagnoses, patients in need of services or not at goal, and preventive care status P-5.1. Metric: Documentation of registry automated report a. Numerator: number of patients with required information entered in the registry b. Denominator: total number of patients with target condition c. Data Source: Registry d. Rationale/Evidence: To be meaningful for panel management and potentially for population health purposes, registry functionality should be able to produce reports for groups or populations of patients that identify clinical indicators. e. Goal: 20% of patients, (1,000 patients) entered by 9/30/14 Milestone 3: P-5 Estimated Incentive Payment *(maximum amount):* $1,593,488	to identify patients and families that would benefit from targeted patient education services. Develop and implement patient and family training programs, education, and/or teaching tools related to the target patient group using evidence-based strategies such as: teach-back, to reinforce and assess if patient or learner is understanding, patient self-management coaching, medication management, nurse and/or therapist-based education in primary care sites, group classes or patients' homes and standardized teaching materials available across the care continuum. I-17.2. Metric: Development of tool for documenting the existence of patient's self-management goals in patient record for patients with chronic disease(s) at defined pilot sites(s). Goal: Tool developed by 9/30/15 Milestone 5: I-17 Estimated Incentive Payment *(maximum amount):* $1,591,018	

138910807.1.3	*1.3.1*	*1.3.1 A, B, C, D*	**Implement and Utilize Pediatric-Specific Disease Management System Functionality**	
Children's Medical Center				138910807
Related Category 3 Outcome Measure(s):	*138910807.3.3*	*IT-9.3*	*Pediatric and Young Adult Asthma Emergency Visits – NQF 1381*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $3,116,049	Year 3 Estimated Milestone Bundle Amount: $3,186,977		Year 4 Estimated Milestone Bundle Amount: $3,182,036	Year 5 Estimated Milestone Bundle Amount: $2,569,346
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 12,054,408				

Project Option 1.12.2 - Enhance Community-Based settings Where Behavioral Health Services May Be Delivered in Underserved Areas

Unique Project ID: 138910807.1.4
Performing Provider Name/TPI: Children's Medical Center/138910807

Provider: Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine. Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. Annually, Children's has approximately 600,000 patient contacts.

Provider's role in region's health care infrastructure (especially for Medicaid and indigent/uninsured): Children's has the largest market share for pediatrics in DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured).

MyChildren's payor mix is 75% Medicaid, 15% CHIP, 5% uninsured and 5% commercial insurance.

Intervention: The purpose of this project is to bring behavioral health services into the primary care setting through the MyChildren's offices. It is a new initiative.

Need for the Project: The need for this project is documented in the community needs (CN) assessment, specifically: CN. 3 Healthcare capacity, CN. 4: Primary Care and Pediatrics, CN 8: Chronic Disease, CN. 9: Specialty Care and CN. 12 Emergency Department Usage and Readmissions.

Target Population: Children covered by Medicaid and CHIP who have behavioral health needs and use MyChildren's for their primary care provider. Estimated number of patients to be served over course of waiver period 4,700 patients. Provide behavioral health services to children in the medical home setting to allow for more rapid access to behavioral health services and better coordination of behavioral and medical services for children and their families.

Intervention	DY3	DY4	DY5
Behavioral health patients	2,600	3,500	4,500

It is estimated that 95% of the above patient population will be in the targeted patient population based on the current MyChildren's payor mix.

Category 1 & 2 Expected Benefit: Process and improvement milestones were selected to support the successful implementation of the project.

Category 3 Outcome: IT 1-20 Other Outcome Improvement Target: Follow-up visits after new anti-depressant medication prescription. This is a provider-defined outcome measure. This improvement target was selected to support the appropriate management of pediatric patients when a new antidepressant is started based on guidelines by the FDA. It is important to have frequent contact with pediatric patients during initiation of an antidepressant due to potential for worsening of symptoms and increased suicidal ideations.

The project will not use additional federal grant dollars.

Project Description

This project is based on community needs and local data that demonstrate the project is addressing an area of poor performance (pediatric access to behavioral health care integrated into a medical home). Expand pediatric behavioral health capacity in CMC primary care settings to align and coordinate care for behavioral and medical illnesses to improve patient/family self-management and reduce unnecessary exacerbation of chronic illnesses. Collaborate with Timberlawn Services for coordination of care between medical services and behavioral health services.

Goals and Relationship to Regional Goals

The goals of the project are to:

- Build clinical protocols with primary care physicians and psychiatrists
- Place pediatric behavioral health capacity (social workers and psychologists) in primary care settings
- Integrate behavioral health and medical health treatment plans into a family-focused, comprehensive and culturally appropriate approach, using a care team approach
- Improve coordination of care between behavioral health and medical providers

The goals address regional goals of better coordination of care between behavioral health and medical providers and increasing access to behavioral health services.

Challenges

A major challenge will be to identify, recruit and retain pediatric behavioral health staff. Second, another challenge will be the development of processes and protocols to integrate behavioral health services into the primary care setting and align/integrate behavioral health and medical services. We will be working with Timberlawn Psychiatric Services, which currently provides inpatient and outpatient behavioral health services to children and adolescents in Dallas County, and other behavioral health providers in RHP 9 to assist us in overcoming the challenges noted. We will also be working with the Pediatric Psychiatry division of the

Department of Psychiatry at UT Southwestern Medical Center to assist us in recruitment of staff and development of processes and protocols.

Five-year Expected Outcomes to Provider and Patients:

- Increase behavioral health visits in primary care center
- Transition appropriate patients from specialty mental health care to primary care
- Implement primary care-initiated behavioral health visits in primary care clinic

Starting point/baseline

In 2011, there were no behavioral health services available in the MyChildren's locations. As a result, medical professionals and behavioral health professionals were treating the same children without common evidence-based protocols and without an integrated family-focused, comprehensive and culturally appropriate care team approach.

Rationale

According to Regional Health Partnership IX Community Needs Assessment Report, Dallas Fort Worth Hospital Council, 2012, the behavioral health (mental health and substance abuse) system in Dallas County is delivered via the NorthSTAR program, instead of a traditional local mental health authority system. Since the program's inception, the growth in enrollment has outpaced funding such that the funding per person is 30% less today than when the program started in 1999. Texas ranks 50th nationally in mental health funding. Despite the strong relationship between behavioral health and medical illness related outcomes and costs, the percentage of the 200% FPL population receiving behavioral health care to primary care settings is below the national average in Dallas County (19.8% vs. 37.1%). Children's Medical Center, one of the largest providers of primary care to low income populations in Dallas County, is not a NorthSTAR provider, and consequently, children who may be successfully served in primary care settings are referred to NorthSTAR. This results in dilution of limited NorthSTAR funds, inadequate services available to children, and coordination of care issues.

According to Regional Health Partnership IX Community Needs Assessment Report, Dallas Fort Worth Hospital Council, 2012, the number of Dallas County children who are receiving publicly funded mental health services has tripled from 2000 to 2010. In Dallas County, the number of children identified with a diagnosable emotional disturbance or addictive disorder has increased to approximately 142,000 children, with 5% of those children experiencing a significant impairment as a result. Among youth between the ages of 12-17, 7.2% have experienced a major depressive episode. However, mental health services available to children are limited and are often times not adequately covered by private and public insurance plans. Services in the health care community frequently do not include the family-focused and comprehensive approach needed to adequately address these issues. Rather, nearly all of the intensive service availability, including evidence-based programs such as multi-systemic

therapy, is provided through the Juvenile Justice System. Furthermore, the number of youth served in the juvenile justice system is increasing, as evidenced by a 17% increase in the number of children receiving psychotropic medications in juvenile detention from 2010 to 2011.

Hispanics comprise 40% of the population but only 25% of the NorthSTAR population. While there is a lack of services available and written materials available in Spanish, it is difficult to characterize the extent of the need, because data on primary language is not collected.

Expanded pediatric behavioral health capacity and integration with medical care in the primary care setting in a family-focused, comprehensive and culturally appropriate manner will improve access for children to behavioral health services, prevent unnecessary exacerbation of chronic illnesses, improve patient/family self-management and improve cost and quality outcomes. The result will be reduced ED visits, specialty care visits and preventable admissions/readmissions for the identified population.

The milestones and metrics for this project are based on the relevancy to RHP9 population, the community need, RHP priority and the starting point.

Intervention	DY3	DY4	DY5
Behavioral health patients	2,600	3,500	4,500

It is estimated that 95% of the above patient population will be in the targeted patient population based on the current MyChildren's payor mix.

While the patient volumes are low for this project, it is believed that it a vital project which can result in substantial total cost savings by appropriately managing pediatric patients with behavioral health issues, children can remain and be successful in school and stay out of the juvenile criminal justice system where a higher percentage of juveniles have untreated or undertreated behavioral health issues.

Project Components

There are no project components for this project.

Community Needs (CN) Addressed:

- CN.4: Primary Care and Pediatrics
- CN.5: Behavioral Health
- CN.6: Behavioral Health and Primary Care
- CN.12: Emergency Department Usage and Readmissions.

Project Represents a New Initiative

In 2011, there were no behavioral health services available in the MyChildren's locations. As a result, medical professionals and behavioral health professionals were treating the same children without common evidence-based protocols and without an integrated family-focused, comprehensive and culturally appropriate care team approach. This project will bring behavior health professionals into the MyChildren's locations to work side-by-side with medical professionals.

Related Category 3 Outcome Measure

Category 3 Outcome: IT 1-20 Other Outcome Improvement Target: Follow-up visits after new anti-depressant medication prescription. This is a provider-defined outcome measure. This improvement target was selected to support the appropriate management of pediatric patients when a new antidepressant is started based on guidelines by the FDA. It is important to have frequent contact with pediatric patients during initiation of an antidepressant due to potential for worsening of symptoms and increased suicidal ideations.

Relationship to other projects

138910807.1.1 Expand Pediatric Primary Care
138910807.1.2 Expand Pediatric Primary care Hours
138910807.1.4 Expand Pediatric Behavioral Health
138910807.2.1 Expand/Enhance Medical Homes
138910807.2.2 Implement/Enhance Evidence-based Health Promotion Programs
138910807.2.3 Expand/Enhance Patient/Family Navigation
138910807.2.4 Implement/Expand Care Transitions Program
RD-1 Potentially Preventable Admissions
RD-2 30-day readmissions
RD-3 Potentially Preventable Complications
RD-6 Initial Core Set of Health Care Quality Indicators

This project is related to the other Catgegory 1 and 2 projects proposed by Children's which impact infrastructure and practices in the MyChildren's locations: additional sites, extended hours, nurse triage phone line, disease management and NCQA certified medical homes.

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

139485012.2.2: BUMC - Colocate/integrate primary and behavioral health
137252607.2.1: Metrocare - Integrate primary care and behavioral health
1372526072.3: Metrocare – Family Preservation Program
1372526072.4: Metrocare – Center for Children with Autism
137252607.1.2: Metrocare - Increase number of community-based settings in underserved area
135234606.2.2: Denton County MHMR – Integrate primary care and behavioral health

We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

This project was valued using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	7	1.40
Population Served / Project Size	25%	7	1.75
Alignment with Community Needs	20%	9	1.80
Cost Avoidance	15%	6	0.90
Sustainability	15%	8	1.20
Partnership Collaboration	5%	9	0.45
	100%		7.50

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact

Moderate Weakness: Lessens impact

Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on

HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

The project will not use additional federal grant dollars.

References

1. James P. Smith, Gillian C. Smith Long-term Economic Costs of Psychological Problems During Childhood Social Science & Medicine, v. 71, no. 1, July 2010, p. 110-115.
2. Aalsma MC, Blythe MJ, Tong Y, Harezlak J, Rosenman MB. Insurance Status of Urban Detained Adolescents. Journal of Correct Health Care. 2012 Aug 23. [Epub ahead of print]
3. Dumont IP, Olson AL, Primary care, depression, and anxiety: exploring somatic and emotional predictors of mental health status in adolescents. J Am Board Fam Med 2012 May-Jun; 25(3):291-9.
4. Jacob MK, Larson JC, Craighead WE Establishing a Telepsychiatry Consultation Practice in Rural Georgia for Primary Care Physicians: A Feasibility Report. Clin Pediatr (Phila). 2012 Apr 20.

138910807.1.4	***1.12.2***	***NO COMPONENTS***	Expand Behavioral Healthcare Capacity	
Children's Medical Center				138910807
Related Category 3 Outcome Measure(s):	*138910807.3.4*	*IT-1.20 Other Outcome Improvement Target*	*Follow-Up After New Antidepressant Prescription*	
Year 2 (10/1/2012 – 9/30/2013)	**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): Identify licenses, equipment requirements and other components needed to implement and operate options selected. P-2.1. Metric: Develop a project plan and timeline detailing the operational needs, training materials, equipment and components • Research existing regulations pertaining to the licensure requirements of psychiatric clinics in general to determine what requirements must be met. • When required, obtain licenses and operational permits as required by state, county or city in which clinic will operate. a. Data Source: Project Plan b. Goal: Plan developed by 9/30/13 Milestone 1 P.2 Estimated Incentive Payment *(maximum amount):* $ 1,558,024 Milestone 2 (P-4): Hire and train staff to operate and manage projects selected. P-4.1 Metric: Number of staff secured/trained	Milestone 3 (P-3): Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for a mobile clinic or guidelines for a transportation program). P-3.1. Metric: Manual of operations for the project detailing administrative protocols and clinical guidelines A Data Source: Administrative protocols; Clinical guidelines B Goal: Administrative protocols and clinical guidelines established by 9/30/14 Milestone 3: P.3 Estimated Incentive Payment *(max amount):* $ 1,593,488 Milestone 4 (P-6): Establish behavioral health services in new community-based settings in underserved (targeted) areas. P-6.1. Metric: Number of new community-based settings where behavioral health services are delivered a. Number of patients served at these new community-based sites b. Goal: Seven new settings and 1,300 patients served by 9-30-14 c. Data source: Administrative data		Milestone 5 (I-11): Increase utilization of community behavioral healthcare I-11.1 Metric Percent utilization of community behavioral healthcare services. a. Numerator: Number receiving community behavioral healthcare after access expansion. b. Denominator: Number of people eligible for receiving community behavioral health services after access expansion. c. Data source: Claims data and encounter data d. Goal: 40% patients referred receive the service, 360 patients by 9/30/2015. Milestone 5: I.11 Estimated Incentive Payment *(maximum amount):* $ 3,182,036	Milestone 6 (I-11): Increase utilization of community behavioral healthcare I-11.1 Metric Percent utilization of community behavioral healthcare services. a. Numerator: Number receiving community behavioral healthcare after access expansion. b. Denominator: Number of people eligible for receiving community behavioral health services after access expansion. c. Data source: Claims data and encounter data d. Goal: 50% patients referred receive the service, 500 patients by 9/30/2016. Milestone 6: I.11 Estimated Incentive Payment *(maximum amount):* $ $ 2,569,346

138910807.1.4	***1.12.2***	***NO COMPONENTS***	Expand Behavioral Healthcare Capacity	
Children's Medical Center				138910807
Related Category 3 Outcome Measure(s):	*138910807.3.4*	*IT-1.20 Other Outcome Improvement Target*	*Follow-Up After New Antidepressant Prescription*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Project records; Training curricula as develop in P-2 Goal: 3 staff hired and trained by 9-30-13 Milestone 2: P.4 Estimated Incentive Payment $ 1,558,025		Milestone 4: P.6 Estimated Incentive Payment *(maximum amount):* $ 1,593,489		
Year 2 Estimated Milestone Bundle Amount: $ 3,116,049		Year 3 Estimated Milestone Bundle Amount: $ 3,186,977	**Year** 4 Estimated Milestone Bundle Amount: $ 3,182,036	**Year** 5 Estimated Milestone Bundle Amount: $ 2,569,346
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 12,054,408				

Project Option 1.13.1 - Development of Behavioral Health Crisis Stabilization Services as Alternatives to Hospitalization

Unique Project ID: 121758005.1.1
Performing Provider Name/TPI: Dallas County/121758005

Provider: Dallas County, with over 2.4 million residents, is one of the seven Counties in the NorthSTAR behavioral health managed care system, which serves Medicaid eligible and indigent consumers. This project is a new initiative for Dallas County and represents a change in roles from planning, coordination and oversight to direct consumer services.

Interventions: This project will implement a data sharing system among providers that will provide point of service data and outcomes data for planning and quality improvement. The project will also provide the following services to persons in behavioral health crisis as alternatives to emergency department and/or hospitals: crisis call center; mobile crisis teams; telehealth and telemedicine; and post acute intensive case management teams.

Need for the project: This project is needed to reduce the utilization of higher levels of care (hospitals and emergency departments) by consumers in Dallas County and the associated over-representation of persons with behavioral health needs in the Dallas County Jail. The number of persons ordered into behavioral health services through the civil mental health courts has increased from 5,938 in 2007 to 6,830 in 2011 (15% increase). The number of persons committed to the Dallas County Jail who also have a history of receiving behavioral health services has increased from 7% of "jail bookins" in 2007 (6,501 consumers) to 20% in 2012 (13,428 consumers).

Target Population: The target population is residents of Dallas County who need behavioral health crisis stabilization services and who are pending intake into or release from the Dallas County Jail or for whom an Order for Protective Custody for commitment into services is pending before the civil mental health courts. For the past five years, Medicaid and indigent consumers have comprised 58% of those persons placed under an Order of Protective Custody. Currently 20% of all persons booked into the Dallas County Jail have a history of receiving NorthSTAR services.

Category 1 expected patient benefits: The project will serve 150 consumers per month upon initial implementation in the fourth quarter of DY2, increasing to 250 consumers per month in DY3, 350 per month in DY4 and 450 per month in DY5. Consumers will benefit from these services by:

- Easier access to community-based services and less need for hospitalizations
- Reduced unnecessary contact with the criminal justice system
- Fewer episodes of presentations at psychiatric emergency departments
- Increased levels of active recovery and improved quality of life

Category 3 Outcomes: This project will reduce the number of persons in the Dallas County Jail who also need behavioral health services by 2% in DY4 (35 per month) and by 3% in DY5 (50 per month). The project will also reduced the number of persons placed into emergency departments and hospitals through the Order of Protective Custody process by 3.5% in DY4 (25 per month) and by 4.5% (32 per month) in DY5.

Project Description

This project is a new initiative for Dallas County. Services will be delivered by providers who are part of the NorthSTAR services network with an expansion of existing services to the targeted population. The project goal is to develop and implement a menu of integrated and coordinated behavioral health crisis services that can be accessed by consumers instead of emergency departments and/or hospitalization. Services will include integrated and coordinated crisis hotline, telehealth and telemedicine crisis services, mobile crisis teams, and post-acute intensive case management teams. This menu of services will shift demand from acute care services to community based services.

Development of acute care targets will be a central focus of DY 2 and will bring together data sources that have not been previously afforded the opportunity for analysis. For example, one provider captures data regarding involuntary consumer migration patterns through the hospital system. This data can be triangulated with acute care services provided by mobile crisis teams operated by a different provider to identify utilization patterns that will guide the development of acute care strategies specific to the needs of Dallas County. There will be focused planning on developing strategies to implement direct services during the 4th quarter of Demonstration Year 2. Our primary data sharing and service delivery targets are: Parkland's Primary Care Clinics and Emergency Department, Dallas County Jail, City of Dallas Detention Center and any access point where a less restrictive option would be pursued if such services were available.

The planning period in DY 2 concludes with a solid foundation of baseline data and improvement targets. At the end of DY 2, the following will be in place:

- A thorough mapping of the crisis stabilization system
- A permanent capacity for data sharing
- A solid grounding in baseline data to drive executable service delivery targets
- An implementation plan vetted with stakeholders and tailored to meet the needs of consumers in acute distress within the challenges of the local landscape

Service implementation begun fourth quarter of DY 2 continues in DY 3-5 with fully functioning:

- Data sharing and system reporting that allows policymakers informed decision making concerning the most expensive components of the service delivery system
- Crisis Call center access for the target population
- Mobile crisis teams for the target population
- Telehealth and telemedicine
- Post acute intensive case management teams

Challenges Faced by Performing Provider

Dallas County as an entity has a unique role in the continuum of behavioral health services available in RHP 9. Through its Sheriff's Department, Dallas County has statutory responsibility for operating the Dallas County Jail. As is true with other jurisdictions across the State, persons with significant behavioral health treatment needs comprise a disproportionate percentage of the jail population. Dallas County has developed and implemented several programs for identifying those in jail and diverting them into community-based services when appropriate. However, hospitalization remains the primary option for persons in behavioral health crisis. Many consumers who are appropriate for diversion from jail require stabilization that is not available in the jail or community.

Dallas County's governing body, the Dallas County Commissioners Court, has statutory authority to approve the annual budget and tax rate for the Dallas County Hospital District. Parkland Memorial Hospital is the centerpiece of the hospital district. Through the main hospital campus and the associated network of Community Oriented Primary Care Clinics (COPC), Parkland is the primary provider of health care to the medically indigent residents of Dallas County. As with most safety net hospitals, Parkland faces constant pressures in providing adequate access to care. Persons presenting at a community clinic who are in behavioral health crisis are often directed to psychiatric hospitalization as there are not resources at the clinics to address the crisis.

Dallas County is one of seven counties that comprise the North Texas Behavioral Health Authority (NTBHA) service region. NTBHA is the statutory local mental health authority for the NorthSTAR managed care system. NorthSTAR is a "carve out" system where Medicaid and medically indigent consumers in the seven county service area receive behavioral health services from a network of providers contracted to a single behavioral health organization (BHO), Value Options. The NorthSTAR system has been very effective in achieving the efficiencies expected from any managed care delivery system. However, funding from the State of Texas has not kept pace with the demand for services. NorthSTAR has responded by reducing the availability of community-based outpatient services to ensure that consumers can continue to access hospitalization and medication services. The lack of funding in NorthSTAR has further increased the reliance on hospitalization for crisis resolution.

Impact of Project on Dallas County Challenges

Increased access to behavioral health crisis stabilization services will have a positive impact on the challenges faced by Dallas County as follows:

- More people can be diverted from the Dallas County Jail if they can be referred to the planned crisis stabilization services.
- Persons presenting in crisis at the Parkland COPC clinics can access community-based services instead of being referred to a hospital or, in many cases, committed to a hospital through the mental health courts process.
- Decreased utilization of hospitalization for behavioral health crisis will reduce the amount of NorthSTAR funding allocated to higher levels of care, including hospitalization, and free up more funding to be allocated to community-based services.

Project's Relationship to Regional Goals

This project is well aligned with the three priories around which the Region 9 plan was developed as follows:

- Reduce Capacity Restraints: This project will provide additional service capacity for persons in behavioral health crisis that is not currently available.
- Improve Care Coordination and Management: The services provided under this project will include resources specifically designed to increase care coordination and management. The improved data sharing, collection and reporting will allow for a system-wide analysis of care coordination/management with data-driven improvements.
- Strengthen Provider Performance: The improved data analysis available through this project will allow individual providers access to outcome data that will lead to improved performance.

5-year Expected Outcomes for Performing Provider and Consumers

The expected outcomes for Dallas County include:

- Reduced jail population and lower cost for treating inmates with behavioral health needs in the jail.
- Reduced numbers of involuntary commitments to hospitalization through the Mental Health Courts.
- Reduced utilization of hospitalization for persons in behavioral health crisis, which will lower NorthSTAR expenditures for higher levels of care and increase funding available for community-based services.

This project is focused on NorthSTAR eligible consumers, who are all either Medicaid eligible or indigent. In 2012, 20% of the persons "booked into" the Dallas County Jail have received

NorthSTAR services in the past. 58% of the consumers committed into behavioral health services through an Order of Protective Custody are either Medicaid eligible or indigent. Expected quality of life outcomes for consumers/patients include:

- Easier access to community-based services and less need for hospitalizations
- Reduced unnecessary contact with the criminal justice system for persons with behavioral health disorders.
- Fewer episodes of presentations at psychiatric emergency departments
- Increased levels of active recovery from their behavioral health challenges and improved quality of life

Starting Point/Baseline

Dallas County Jail 1-1-2007 through 9-30-2012

The number of persons detained at the Dallas County Jail compared to the number of those persons who have a history of receiving public behavioral health services through NorthSTAR provides a baseline for the volume of behavioral health consumers in the jail. While the number of persons detained has decreased since 2008, the proportion of persons with a NorthSTAR history has increased.

Year	Total inmates detained	Total inmates with history of NorthSTAR services	Percent of inmates with NorthSTAR history
2007	93,413	6,501	7%
2008	99,580	8,200	8%
2009	98,407	10,636	11%
2010	96,245	12,994	14%
2011	90,429	15,810	17%
2012 (through 9-12)	66,106	13,428	20%

Commitments to Hospitals by Dallas County Mental Health Courts 2007-2011

The data below shows the number of consumers who are transitioned against their will to higher levels of care. On average this currently equates to about 570 consumers per month, which represents a 14% increase as compared to a historical pattern of approximately 500 per month until 2009.

Orders Of Protective Custody	Payor Source For Hospitalization					Total	Originating From Parkland	
Year	Medicaid	Medicare	NS ndigent	NS edicaid	Other		PED & 8N	All Other
2007	151	1326	2500	892	1069	5938	3223	195
2008	161	1398	2496	838	976	5869	3308	176
2009	176	1372	2579	805	1050	5982	3061	145
2010	203	1708	2977	697	1245	6830	3058	150

2011	257	1815	2851	815	1100	6838	2920	163
Grand Total	948	7619	13403	4047	5440	31457	15570	829

Rationale for Project - Community Needs ID: CN.5

This project was selected based on needs identified through current community planning efforts to improve the behavioral health care delivery system. Parkland Hospital and Dallas County collaborated to engage consultants, TriWest/Zia, to conduct a detailed analysis of the behavioral health delivery system in Dallas County. The consultant's assessment included detailed data analysis and interviews with community stakeholders including consumers, family members, providers, advocates, funders, elected officials and other stakeholders. The engagement resulted in a formal report, Assessment of the Community Behavioral Health Delivery System in Dallas County. The final report included a detailed analysis of available cost and outcomes data and recommendations for community action, collectively referred to as the "Twelve Steps for Recovery."

TriWest/Zia recommended the establishment of a formal planning body to focus on implementing the recommendations from the assessment and improving the local behavioral health delivery system. The Dallas County Behavioral Health Leadership Team (BHLT) was chartered by the Dallas County Commissioners Court in January 2011 and has met monthly since. This project has been approved by the BHLT, which will serve as the governing body for the project.

Another of these twelve recommendations for action is the basis for this project. The consultants specifically found that "*The Dallas County system is designed in such a way that it has become highly crisis-reactive, and as a result significant resources are invested in what we would call "back end," more expensive crisis response (for example, psychiatric emergency services and 23-hour observation), rather than lower-cost proactive crisis response that would reduce the "crisis tone" (and crisis cost) in the system over time*." Additionally, TriWest/Zia found that almost 30% of Dallas County residents with severe behavioral health needs were served in the Dallas County Jail in 2010. Finally, TriWest Zia gives evidence that significantly less Dallas County consumers with serious behavioral needs are served outside the primary care setting as compared to national averages (37.1% nationally, 19.8% in Dallas County).

Project Components

a) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps. The existing Dallas County Behavioral Health Leadership Team (BHLT) will serve as the stakeholder group to conduct a gap analysis. The BHLT has broad representation from the community and additional stakeholders will be invited to participate as needed. The BHLT meets monthly with working groups meeting as

needed. A standing committee will be delegated the task of developing the gap analysis and implementation plan for review and approval by the full BHLT.

b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service. The previously referenced consultants' report will serve as the starting point for system analysis. Data reports generated by the BHLT will also be utilized. Additional data will be extracted from current providers as needed.

c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plant to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients. This assessment will be conducted through BHLT. All final recommendations will be approved by BHLT.

d) Explore potential crisis alternative service models and determine acceptable and feasible models for implementation. The BHLT will review the proposed service models and authorize revisions to the service plan if indicated by the data and gap analysis. Once approved by the BHLT, Dallas County will proceed with implementing the needed services, primarily through contracts with existing providers.

e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s). There will be a robust quality improvement process utilized throughout the life of the project. There will be a working group of the BHLT tasked with monthly review of program data and reporting the results of that review to the BHLT each month. The monthly review will include recommendations for program changes as indicated by the data. The monthly data review will include numbers served and diverted from higher levels of care and will be focused on barriers that are encountered and solution for overcoming those barriers.

Milestones and Metrics

The milestones and metrics for this project were developed based upon the RHP Planning Protocol guidance. Each of the process metrics represent a specific step in the planning and implementation process, with appropriate written documentation of all decisions. Once services are initiated, there will be monthly gathering, analysis and reporting of service data.

How the project represents a new initiative for Dallas County

This project will move Dallas County into a new role as a direct service provider. Dallas County will function much like a general contractor for the project, with local providers contracting for direct service provision. Dallas County, through its BHLT, will manage this project, provide the required IGT matching funds and report outcomes. The BHLT will be the primary vehicle for reviewing project outcomes and adjusting service delivery as needed.

Related Category 3 Outcomes Measure

- IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
- IT-9.2 ED appropriate utilization

Rationale for selecting outcomes

These two outcome measures directly capture the goals of this project. Local and national data indicate that persons with a history of frequent jail admissions also have a history of increased use of behavioral health services, especially higher levels of crisis services including emergency departments. The interventions in this project will reduce the number of persons cycling through the local jail and the number of jail admissions for persons with a history of jail recidivism. The project interventions will also reduce the number of persons accessing emergency departments who have behavioral health treatment needs. These two outcomes measures will show if the project has the predicted impact both on the entire system in reduced costs for jail and emergency department utilization and on those persons who receive the project services in less time in jail, fewer behavioral health crisis and improved progress towards personal recovery.

Relationship to other Projects

Other projects submitted for RHP9 related to improving the behavioral health system include:

138910807.1.4 -Children's Medical Center	121988304.1.1- Lakes Regional MHMR
121988304.1.2- Lakes Regional MHMR	020943901.1.3- Medical City Dallas Hospital
135234606.2.1- Denton County MHMR	135234606.2.2- Denton County MHMR
135234606.2.3- Denton County MHMR	127295703.2.2- Parkland Hospital System

Plan for Learning Collaborative. Dallas County will be active in the development and ongoing conduct of Project Learning Collaboratives, appropriate to this project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. Dallas County will also participate in any Outocmes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. Dallas County believes that the exchange of best practices and shared learning will contribute significantly to continuous quality improvement and will advance the project.

Project Valuation

This project is valued based upon the costs of reducing jail stays and the costs avoided by providing community based crisis services instead of the more expensive services through emergency departments and psychiatric hospitalizations. The Category 1 and associated Category 3 projects have a total value of IGT and Federal funds of $19,799,339. The project will divert 35 individuals from jail each month of DY3 and DY4 and 50 per month in DY5. At a cost of $10,960 for a jail stay (police, jail and healthcare in jail) for a person with behavioral health needs, these 1,440 jail stays that are avoided have a combined value of $15,782,400. The project will divert 25 people from court ordered behavioral health services each month of DY3 and DY4 and 32 per month in DY5. At a combined system cost of $4,300 per court commitment (cost for police, courts and treatment), these 984 diversions have a combined value of $4,231,200. These value calculations do not include other costs expected to be avoided, such as placement in the state hospitals at a cost of $11,692 per stay.

121758005.1.1	*1.13.1*	*1.13.1(A-E)*	*DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION*	
Dallas County				*121758005*
Related Category 3 Outcome Measure(s):	*121758005.3.1* *121758005.3.2*	*IT-9.1* *IT-9.2*	*Decrease Mental Health Admissions/Readmissions to Criminal Justice Settings* *ED Appropriate Utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Conduct stakeholder meetings <u>Metric 1.1</u> # of stakeholder meetings Baseline/Goal: 3 meetings Data Source: attendance lists and meeting notes Milestone 1 Estimated Incentive Payment *(maximum amount):* $667,094 **Milestone 2 [P-2]** Complete mapping and gap analysis of current crisis system <u>Metric 2..1</u> Baseline/Goal: written gap analysis Data Source: written plan approved by BHLT Milestone 2 Estimated Incentive Payment: $667,094 **Milestone 3 [P-3]** Develop written implementation plan for needed crisis services <u>Metric 3.1</u> Written Implementation Plan Baseline/Goal: Written implementation plan	**Milestone 7 [I-X] (Custom)** Continue providing crisis stabilization services to consumers based on approved plans <u>Metric X.1</u> # of consumers served, reported on a monthly basis Baseline/Goal: This is a new service. Goal is to serve 250 consumers/month in DY3 Data Source: program records Milestone 7 Estimated Incentive Payment *(maximum amount):* *$*879,062 **Milestone 8 [P-6]** Evaluate and continuously improve crisis services <u>Metric 6.1</u> Documentation from BHLT meetings as evidence that data from service delivery is reviewed, evaluated, and, as indicated, service protocols are revised Baseline/Goal: monthly quality improvement reviews Data Source: BHLT attendance lists and meeting notes and program data		**Milestone 12 [I-X] (Custom)** Continue providing crisis stabilization services to consumers based on approved plans <u>Metric X.1</u> # of consumers served, reported on a monthly basis Baseline/Goal: This is a new service. Goal is to serve 350 consumers/ month in DY4 Data Source: program records Milestone 12 Estimated Incentive Payment *(maximum amount):* $783,660 **Milestone 13 [P-6]** Evaluate and continuously improve crisis services <u>Metric 6.1</u> Documentation from BHLT meetings as evidence that data from service delivery is reviewed, evaluated, and, as indicated, service protocols are revised Baseline/Goal: monthly quality improvement reviews Data Source: BHLT attendance lists and meeting notes and program data	**Milestone 18 [I-X] (Custom)** Continue providing crisis stabilization services to consumers based on approved plans <u>Metric X.1</u> # of consumers served, reported on a monthly basis Baseline/Goal: This is a new service. Goal is to serve 450 consumers/month in DY5 Data Source: program records Milestone 18 Estimated Incentive Payment *(maximum amount):* *$*757,159 **Milestone 19 [P-6]** Evaluate and continuously improve crisis services <u>Metric 6.1</u> Documentation from BHLT meetings as evidence that data from service delivery is reviewed, evaluated, and, as indicated, service protocols are revised Baseline/Goal: monthly quality improvement reviews Data Source: BHLT attendance lists and meeting notes and program data

121758005.1.1	*1.13.1*	*1.13.1(A-E)*	*DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION*	
Dallas County				*121758005*
Related Category 3 Outcome Measure(s):	*121758005.3.1* *121758005.3.2*	*IT-9.1* *IT-9.2*	*Decrease Mental Health Admissions/Readmissions to Criminal Justice Settings* *ED Appropriate Utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: written plan approved by BHLT Milestone 3 Estimated Incentive Payment *(maximum amount):* $667,094 **Milestone 4 [P-5]** Develop operational protocols and clinical guidelines for crisis services <u>Metric 5.1</u> Completion of written policies and procedures approved by BHLT Baseline/Goal: written policy/procedures document Data Source: written document Milestone 4 Estimated Incentive Payment *(maximum amount):* $667,094 **Milestone 5 [P-4]** Hire and train staff to implement identified crisis stabilization services <u>Metric 4.1</u> # of staff hired and trained Baseline/Goal: Data Source: staff rosters and training records	reports Milestone 8 Estimated Incentive Payment *(maximum amount):* *$*879,062 **Milestone 9 [P-7]** Participate in bi-weekly learning interactions with project providers, other providers and the RHP (as appropriate) to share challenges and solutions <u>Metric 7.1</u> # of learning interactions Baseline/Goal: at least bi-weekly learning interactions Data Source: attendance lists and meeting notes Milestone 9 Estimated Incentive Payment *(maximum amount):* *$*879,062 **Milestone 10 [P-8]** Review project data and respond with tests of new practices <u>Metric 8.1</u> # of new ideas, solutions, practices tested by providers Baseline/Goal: at least 3 new		reports Milestone 13 Estimated Incentive Payment *(maximum amount):* $783,660 **Milestone 14[P-7]** Participate in bi-weekly learning interactions with project providers, other providers and the RHP (as appropriate) to share challenges and solutions <u>Metric 7.1</u> # of learning interactions Baseline/Goal: at least bi-weekly learning interactions Data Source: attendance lists and meeting notes Milestone 14 Estimated Incentive Payment *(maximum amount):* $783,660 **Milestone 15[P-8]** Review project data and respond with tests of new practices <u>Metric 8.1</u> # of new ideas, solutions, practices tested by providers Baseline/Goal: at least 3 new	reports Milestone 19 Estimated Incentive Payment *(maximum amount):* *$*757,159 **Milestone 20[P-7]** Participate in bi-weekly learning interactions with project providers, other providers and the RHP (as appropriate) to share challenges and solutions <u>Metric 7.1</u> # of learning interactions Baseline/Goal: at least bi-weekly learning interactions Data Source: attendance lists and meeting notes Milestone 20 Estimated Incentive Payment *(maximum amount):* *$*757,159 **Milestone 21 [P-8]** Review project data and respond with tests of new practices <u>Metric 8.1</u> # of new ideas, solutions, practices tested by providers Baseline/Goal: at least 3 new

121758005.1.1	*1.13.1*	*1.13.1(A-E)*	*DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION*	
Dallas County				*121758005*
Related Category 3 Outcome Measure(s):	*121758005.3.1* *121758005.3.2*	*IT-9.1* *IT-9.2*	*Decrease Mental Health Admissions/Readmissions to Criminal Justice Settings* *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 5 Estimated Incentive Payment *(maximum amount):* $667,094 **Milestone 6[I-X] (Custom)** Begin providing crisis stabilization services to consumers based on approved plans <u>Metric I- X.1</u> # of consumers served, reported on a monthly basis Baseline/Goal: This is a new service. Goal is to serve 150 consumers per month during DY2 Data Source: program records Milestone 6 Estimated Incentive Payment *(maximum amount):* $667,095	ideas, solutions or practices tested each quarter Data Source: documentation of each new idea, solution or practice tested and outcome of the test – to be collected and reported quarterly Milestone 10 Estimated Incentive Payment *(maximum amount):* *$*879,062 **Milestone 11[P-9]** Participate in at least semi-annual face to face learning collaboratives <u>Metric 9.1</u> # of learning collaborative meetings/work sessions Baseline/Goal: 2 meetings per year Data Source: attendance lists and meeting notes <u>Metric 9.2</u> Implement improvements identified in the semi-annual learning collaborative events Baseline/Goal: at least one improvement implemented from each semi-annual learning collaborative		ideas, solutions or practices tested each quarter Data Source: documentation of each new idea, solution or practice tested and outcome of the test – to be collected and reported quarterly Milestone 15 Estimated Incentive Payment *(maximum amount):* *$*783,660 **Milestone 16 [P-9]** Participate in at least semi-annual face to face learning collaboratives <u>Metric 9.1</u> # of learning collaborative meetings/work sessions Baseline/Goal: 2 meetings per year Data Source: attendance lists and meeting notes <u>Metric 9.2</u> Implement improvements identified in the semi-annual learning collaborative events Baseline/Goal: at least one improvement implemented from each semi-annual learning collaborative Data Source: documentation from each learning collaborative of the identified improvement and the	ideas, solutions or practices tested each quarter Data Source: documentation of each new idea, solution or practice tested and outcome of the test – to be collected and reported quarterly Milestone 21 Estimated Incentive Payment *(maximum amount):* *$*757,160 **Milestone 22[P-9]** Participate in at least semi-annual face to face learning collaboratives <u>Metric 9.1.3</u> # of learning collaborative meetings/work sessions Baseline/Goal: 2 meetings per year Data Source: attendance lists and meeting notes <u>Metric 9.2</u> Implement improvements identified in the semi-annual learning collaborative events Baseline/Goal: at least one improvement implemented from each semi-annual learning collaborative

121758005.1.1	*1.13.1*	*1.13.1(A-E)*	*DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION*	
Dallas County				*121758005*
Related Category 3 Outcome Measure(s):	*121758005.3.1* *121758005.3.2*	*IT-9.1* *IT-9.2*	*Decrease Mental Health Admissions/Readmissions to Criminal Justice Settings* *ED Appropriate Utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Data Source: documentation from each learning collaborative of the identified improvement and the results of its implementation Milestone 11 Estimated Incentive Payment *(maximum amount):* *$*879,062		results of its implementation Milestone 16 Estimated Incentive Payment *(maximum amount):* *$*783,660 **Milestone 17 [I-11]** Costs avoided by using lower costs crisis alternative settings <u>Metric I-11.1</u> Costs avoided by comparing utilization of lower costs alternative settings with higher cost settings such as ER, jail, hospitalization Numerator: cost of services for individuals using crisis alternatives Denominator: Total cost for crisis care to individuals in Dallas County Data Source: claims and encounter data from NorthSTAR, Dallas County Jail data, and program records Baseline: to be finalized in DY3, for 2012, crisis services expenses for NorthSTAR were 36% of community based services expenses Goal: Reduce the percentage of expenses on crisis services by 3% Milestone 17 Estimated Incentive Payment *(maximum amount):* *$*783,660	Data Source: documentation from each learning collaborative of the identified improvement and the results of its implementation Milestone 22 Estimated Incentive Payment *(maximum amount):* *$*757,160 **Milestone 23 [I-11]** Costs avoided by using lower costs crisis alternative settings <u>Metric I-11.1</u> Costs avoided by comparing utilization of lower costs alternative settings with higher cost settings such as ER, jail, hospitalization Numerator: cost of services for individuals using crisis alternatives Denominator: Total cost for crisis care to individuals in Dallas County Data Source: claims and encounter data from NorthSTAR, Dallas County Jail data, and program records Baseline: to be finalized in DY3, for 2012, crisis services expenses for NorthSTAR were 36% of community based services expenses Goal: Reduce the percentage of expenses on crisis services by 5%

121758005.1.1	***1.13.1***	***1.13.1(A-E)***	***DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION***	
Dallas County				*121758005*
Related Category 3 Outcome Measure(s):	*121758005.3.1* *121758005.3.2*	*IT-9.1* *IT-9.2*	*Decrease Mental Health Admissions/Readmissions to Criminal Justice Settings* *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 17 Estimated Incentive Payment *(maximum amount):* *$*757,160
Year 2 Estimated Milestone Bundle Amount*:* $4,002,565	Year 3 Estimated Milestone Bundle Amount: $4,395,310		Year 4 Estimated Milestone Bundle Amount: $4,701,960	Year 5 Estimated Milestone Bundle Amount: $4,542,957
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $17,642,792				

Project Option 1.14.2 – Behavioral Health Workforce Development Program

Unique Project ID: 137252607.1.1
Performing Provider Name/TPI: Dallas County MHMR Center dba Metrocare Services/137252607

IGT Entity: Dallas County MHMR Center dba Metrocare Services

Provider: Metrocare Services is a behavioral health organization, serving approximately 50,000 persons in Dallas County with mental illness and developmental disabilities.

Intervention: Implement strategies to train behavioral health students/residents to serve medically indigent public health consumers in RHP 9

Need for the project: Community mental health providers like Metrocare primarily serve low-income populations with both social and psychiatric needs. A rapid growth in patients has been coupled with a shortage of professionals willing to care for this population. An aging workforce and existing psychiatrists, outside of the public system, who express an unwillingness to accept new patient with Medicaid make this type of project critical to address future workforce needs.

Target population: Medically indigent clients along with current mental health students being educated to become: psychiatrists, licensed psychologists, nurse practitioners, physician assistants, nurses, social workers, licensed professional counselors, licensed marriage and family therapists, licensed chemical dependency counselors, and peer support specialists.

Category 1 or 2 expected patient benefits: Increased access to professionally trained behavioral healthcare providers.

Category 3 outcomes: We expect improvement in patient satisfaction IT-6.1 with respect to improved access to care and improved relationship with behavioral health providers.

Project Description

Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas (e.g., psychiatrists, psychologists, LMSWs, LPCs, and LMFTs.)

The goal of the project is to enhance access and reduce shortages in specialty behavioral health care and to improve consumer choice, by expanding the number of behavioral health professionals—Psychiatrist, Child Psychiatrists, Psychologist, Licensed Master Social Workers (LMSW), Licensed Professional Counselors (LPC) and Licensed Marriage &Family Therapists (LMFT) trained in a community mental health setting (i.e., at the Center for Education and Research at Metrocare (CER). There is a shortage of psychiatric providers in Dallas County. From a report of the Public Consulting Group of all Texas Psychiatrist in 2010, 98.5% indicate that they would not take any new Medicaid patients. Those new patients for behavioral health

services will be turning to the public sector for care. The supply of behavioral healthcare providers is inadequate throughout most of the State.

http://ps.psychiatryonline.org/article.aspx?articleID=85362

Extensive empirical research, summarized in several reviews and codified in practice guidelines, recommendations, and algorithms, demonstrates that several pharmacological and psychosocial interventions are effective in improving the lives of persons with severe mental illnesses. Yet the practices validated by research are not widely offered in routine mental health practice settings.

Using our training to educate students/residents on the use of specific medications prescribed in specific ways as well as the use of psychosocial interventions such as supported employment, various approaches to illness self-management, family psycho-education, case management based on the principles of assertive community treatment, and substance abuse treatment that is integrated with mental health treatment (16).

We are proposing that students/residents do not seek employment serving the medically indigent primarily due to not being exposed to that population during their education. Therefore, the CER plans to train students/residents in behavioral health care throughout Metrocare's wide array of clinical settings. Students are currently receiving excellent education in evidence based practices and we would like to combine that education with real world experience serving the medically indigent. The benefit of this intervention would be two fold. We feel that a percentage of the students/residents that we train will then seek employment serving the medically indigent as they transition into their profession and we also feel that due to this collaboration of real world experience with a present day education the patient satisfaction scores will increase for the patients that are being treated by students/residents.

We plan to improve the behavioral health care by training students/residents using evidence based practices. With that training we provide the evidence based practices of:

Illness Management and Recovery:
Illness management is a broad set of strategies designed to help individuals with serious mental illness collaborate with professionals, reduce their susceptibility to the illness, and cope effectively with their symptoms. Recovery occurs when people with mental illness discover, or rediscover, their strengths and abilities for pursuing personal goals and develop a sense of identity that allows them to grow beyond their mental illness. Research on illness management for persons with severe mental illness, including 40 randomized controlled studies, indicates that psychoeducation improves people's knowledge of mental illness; that behavioral tailoring helps people take medication as prescribed; that relapse prevention programs reduce symptom relapses and re-hospitalizations; and that coping skills training using cognitive-behavioral techniques reduces the severity and distress of persistent symptoms.

http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463

Family Psychoeducation:
Psychoeducation was developed in order to help those suffering with mental illness, as well as others who were seeking information about mental illness. Psychoeducation also fulfills a third function, which is to provide a way for individuals to access and learn strategies to deal with mental illness and the effects it can have on those it touches.

It is important to note that psychoeducation is not a form of treatment, but is instead used as part of an overall plan for treatment. It is documented in the medical field that the more informed an individual becomes regarding his or her condition and its effects on their life; the more the individual can take control over the illness and not the other way around. As a result, the individual suffering with a mental illness can reduce their episodes, as well as enjoy a reduction in intensity and duration.

When whole families are involved in the treatment of someone dealing with a mental illness, it is common for all members to become involved in family psychoeducation. This approach helps to train family members on how best to work together with mental health professionals as part of the overall treatment plan for the individual. When the family approaches management and even recovery as a team, patient outcomes are improved.

As patients with schizophrenia or other mental disorders are trying to re-instate a normal life, family psychoeducation can provide the necessary tools to help guarantee success. Not only are individuals able to return home more quickly with the use of family psychoeducation, they also have increased rates of participation in vocational rehabilitation and employment, decreased costs of care and improved well-being of all involved family members.

http://store.samhsa.gov/product/Family-Psychoeducation-Evidence-Based-Practices-EBP-KIT/SMA09-4423
Training Therapists in Evidence-Based Practice: A Critical Review of Studies From a Systems-Contextual Perspective
Rinad S. Beidas, Philip C. Kendall
Clinical Psychology: Science and Practice, Volume 17, Issue 1, pages 1–30, March 2010
Article first published online: 10 MAR 2010
DOI: 10.1111/j.1468-2850.2009.01187.xEvidence-based practice (EBP), a preferred psychological treatment approach, requires training of community providers. The systems-contextual (SC) perspective, a model for dissemination and implementation efforts, underscores the importance of the therapist, client, and organizational variables that influence training and consequent therapist uptake and adoption of EBP. This review critiques the extant research on training in EBP from an SC perspective. Findings suggest that therapist knowledge improves and attitudinal change occurs following training. However, change in therapist behaviors (e.g., adherence, competence, and skill) and client outcomes only occurs when training interventions address each level of the SC model and include active learning. Limitations as well as areas for future research are discussed.
David N. Osser, M.D.; Robert D. Patterson, M.D.; James J. Levitt, M.D.
Academic Psychiatry 2005;29:180-186. 10.1176/appi.ap.29.2.180Public-Academic Partnerships: Public Psychiatry Fellowships: A Developing Network of Public-Academic Collaborations

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals

- To enhance access and reduce shortages in specialty behavioral health care.
- To Increase the number of outpatient psychiatric residents and other behavioral health trainees rotating through the Center for Education and Research.
- To enhance the best practices and quality of care, students/residents will promote recovery from behavioral health disorders.

Challenges

Community mental health providers like Metrocare primarily serve low-income populations with both social and psychiatric needs. A rapid growth of patients has been coupled with a shortage of professionals willing to care for this challenging population.

Organizations that traditionally treat the medically indigent do not have dedicated resources to support and train individuals that may be interested in treating the medically indigent population. The Center for Education and Research at Metrocare is confident that if trainees are mentored by dedicated staff to provide high quality education and supervision that not only will the consumers be more satisfied with treatment but some trainees will seek employment in a community mental health setting.

5-Year Expected Outcome for Provider and Patients

- Baseline is 12.
- Increase number of behavioral health students/residents trained by 24 over baseline in DY2
- Increase Medicaid eligible/indigent being treated for a behavioral health condition from baseline 500 to 750 in DY2
- Increase behavioral health students/residents trained by 36 over baseline in DY3
- Increase Medicaid eligible/indigent being treated for a behavioral health condition from baseline 750 to 1000 in DY3
- Increase behavioral health students/residents trained by 48 over baseline in DY4
- Increase Medicaid eligible/indigent being treated for a behavioral health condition from baseline 1000 to 1250 in DY4
- Increase behavioral health students/residents trained by 60 over baseline in DY5

- Increase Medicaid eligible/indigent being treated for a behavioral health condition from baseline 1250 to 1500
- Increase in patient satisfaction scores
- Increase in number of trainees that enter the workforce treating the Medicaid eligible/indigent from 2 in DY3, 7 in DY4 and 12 in DY5

Rationale

The current shortage of public behavioral health practitioners, especially those within the field of psychiatry is of great concern. A survey conducted by a national physician search also indicates the demand in this field is growing faster than any other medical specialty. One in four adults in the U.S. experiences a diagnosable mental illness in a given year. Six percent have a serious mental illness. Nearly half of all adults in the U.S. will have a diagnosable mental health condition in their lifetime. People experiencing mental illness can achieve recovery and wellness when appropriate mental health services and supports are available. Metrocare would like to leverage its broad range of clinical services to offer a unique and rewarding education experience to its trainees. For example trainees could complete rotations in our dual diagnosis residential treatment center, on an ACT team, in our special needs offender program, the autism program, the new onset program, treatment foster care, therapeutic foster care, and behavioral psychological services.

The customized process milestone was created for this project in order to evaluate the programs' success at training a larger quantity of students/residents year after year. In addition, the improvement milestone was also created for this project to show a year after year increase in the number students/residents that seek employment serving the medically indigent once their education and training has been completed.

Project Components

Project Option 1.14.2 has no project components. It is an "other" project option.

Unique community need identification numbers the project addresses

- CN.5: Behavioral Health
- CN.6: Behavioral Health and Primary Care
- CN.7: Behavioral Health and Jail Population

How the project represents a significant enhancement to an existing delivery system reform initiative

This project is an enhancement to the behavioral health care delivery system by training additional staff in an innovative manner to encourage their career track in the public mental health care system. This project will do much to address the shortage of behavioral health providers.

Related Category 3 Outcome Measure(s)

IT-6.1 Percent improvement over baseline of patient satisfaction scores

This protocol was chosen in order to connect the training and increase in number of professionals employed to serve the medically indigent client back to an emphasis on patient satisfaction.

The CER must remain focused not only on high quality training of best clinical practices but also on tracking and monitoring patient satisfaction scores. Patient satisfaction scores should lead our trainees in understanding that a patient whom is engaged and satisfied with his/her treatment is more likely to remain stable and use less intensive services than a patient whom is not satisfied with his or her care.

The CER is confident that the collaborative nature of combining mental health classroom education with a real world experience using evidence based practices along with supervision will produce higher satisfaction scores in the clients that have been treated by a resident and/or student versus a client that has not been treated by a student and/or resident.

Relationship to Other Projects

This Public Behavioral Health Workforce Development project compliments the other Metrocare projects which create infrastructures to handle a wide array of clinical needs with an anticipated increased volume of patients. The project addresses some of the human resource/workforce development and preparation needed for all of the projects.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Other projects submitted for RHP9 related to improving the delivery system for behavioral health include:

138910807.1.4 Children's Medical Center	121988304.1.1 Lakes Regional MHMR
121988304.1.2 Lakes Regional MHMR	020943901.1.3 Medical City Dallas Hospital
135234606.2.1 Denton County MHMR	135234606.2.2 Denton County MHMR
135234606.2.3 Denton County MHMR	127295703.2.2 Parkland Health System

Plan for Learning Collaborative. We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV-Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The true value of the Behavioral Health Workforce Initiative (The Center for Education and Research) will be realized in the future. Identifying the declining deficit of qualified mental health professionals now, highlights the issue and allows the community to address the problem and work on a solution. "Most Texas counties are federally designated mental health professional shortage areas as of March 2010." (Mental Health of Texas)

Training now will provide the needed staff for the future. The CER encourages local trainees/psychiatry residents to explore the public mental health sector. As these individuals choose to work in this setting the ever growing census of patients needing help will have qualified professionals to care for them. Each new psychiatrist working in a mental health clinic can carry a patient load of 800 patients, seen throughout a calendar year. When there are doctors in a community, the patients care is increased with more frequent visits. Transportation to out of county resources is no longer an issue, and patients are more apt to remain in the work force and stable in their family structure.

Unique Identifier: 137252607.1.1	***Project Option:*** *1.14.2*	***Project Components:*** *NA*	***Title****: Behavioral Health Workforce Development Program*
Performing Provider: Dallas County MHMR Center d/b/a Metrocare Services			*TPI:* 137252607
Related Category 3 Outcome Measures :	*137252607.3.1*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2] Remediation Plan. Metric 2.1: Remediation plan which addresses elements relating to shortages identified in the gap analysis. Goal: To derive information to guide program development and priorities. Data Source: Literature review, survey of stakeholders, Metrocare Human Resources System, Region 9 community needs assessment Milestone 1 Estimated Incentive Payment (max amount): $95,463 **Milestone 2**[P-X] Behavioral health provider training for students/residents. Metric X.1: Track and report the number of behavioral health providers who have been trained to manage behavioral health conditions in medically indigent public health clients. Goal: Increase trainees enrolled from baseline 12 to 24 Data Source: Training rosters Metric X.2: Track and report the number of Medicaid eligible/indigent that are being treated by trainees. Goal: Increase Medicaid eligible/indigent being treated for a	**Milestone 3** [P-X] Behavioral health provider training for students/residents. Metric X.1: Track and report the number of behavioral health providers who have been trained to manage behavioral health conditions in medically indigent public health clients. Goal: Increase trainees enrolled from baseline 24 to 36 Data Source: Training rosters Metric X.2: Track and report the number of Medicaid eligible/indigent that are being treated by trainees. Goal: Increase Medicaid eligible/indigent being treated for a behavioral health condition from baseline 750 to 1000 Data Source: Metrocare clinical software Milestone 3 Estimated Incentive Payment (max amount): $166,037 **Improvement Milestone 4** [I-X] Enter the workforce to serve the medically indigent	**Milestone 5** [P-X] Behavioral health provider training for students/residents. Metric X.1: Track and report the number of behavioral health providers who have been trained to manage behavioral health conditions in medically indigent public health clients. Goal: Increase trainees enrolled from baseline 36 to 48 Data Source: Training rosters Metric X.2: Track and report the number of Medicaid eligible/indigent that are being treated by trainees. Goal: Increase Medicaid eligible/indigent being treated for a behavioral health condition from baseline 1000 to 1250 Data Source: Metrocare clinical software Milestone 5 Estimated Incentive Payment (max amount): $264,157 **Improvement Milestone 6** [I-X] Enter the workforce to serve the medically indigent Metric I-X.1:	**Milestone 7** [P-X] Behavioral health provider training for students/residents. Metric X.1: Track and report the number of behavioral health providers who have been trained to manage behavioral health conditions in medically indigent public health clients. Goal: Increase trainees enrolled from baseline 48 to 60 Data Source: Training rosters Metric X.2: Track and report the number of Medicaid eligible/indigent that are being treated by trainees. Goal: Increase Medicaid eligible/indigent being treated for a behavioral health condition from baseline 1250 to 1500 Data Source: Metrocare clinical software Milestone 7 Estimated Incentive Payment (max amount): $290,024 **Improvement Milestone 8** [I-X] Enter the workforce to serve the medically indigent

Unique Identifier: 137252607.1.1	***Project Option:*** *1.14.2*	***Project Components:*** *NA*	***Title****: Behavioral Health Workforce Development Program*
Performing Provider: Dallas County MHMR Center d/b/a Metrocare Services			*TPI:* 137252607
Related Category 3 Outcome Measures :	*137252607.3.1*	*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)**
behavioral health condition from baseline 500 to 750 Data Source: Metrocare clinical software Milestone 2 Estimated Incentive Payment (max amount): $95,464	<u>Metric I-X.1:</u> Numerator: Number of CER trained students/residents that find employment treating the medically indigent following their education/training. Denominator: Number of CER trained students/residents Goal: 10% of CER trained students/residents will find employment serving the medically indigent Data Source: Metrocare Training Rosters Milestone 4 Estimated Incentive Payment (max amount): $166,037	Numerator: Number of CER trained students/residents that find employment treating the medically indigent following their education/training. Denominator: Number of CER trained students/residents Goal: 15% of CER trained students/residents will find employment serving the medically indigent Data Source: Metrocare Training Rosters Milestone 6 Estimated Incentive Payment (max amount): $ 264,157	<u>Metric I-X.1:</u> Numerator: Number of CER trained students/residents that find employment treating the medically indigent following their education/training. Denominator: Number of CER trained students/residents Goal: 20% of CER trained students/residents will find employment serving the medically indigent Data Source: Metrocare Training Rosters Milestone 8 Estimated Incentive Payment (max amount) : $ 290,048
Year 2 Estimated Milestone Bundle Amount: $190,927	Year 3 Estimated Milestone Bundle Amount: $332,074	Year 4 Estimated Milestone Bundle Amount: $492,314	Year 5 Estimated Milestone Bundle Amount: $580,048
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,595,363			

Project Option: 1.12.2 – Expansion of Behavioral Health Outpatient Services for Children, Families and Adults
Unique Project ID: 137252607.1.2 (Pass 2)

Performing Provider/TPI: Dallas County MHMR dba Metrocare Services/ 137252607

Provider: Metrocare Services is a behavioral health organization, serving approximately 50,000 persons in Dallas County with mental illness and developmental disabilities.

Interventions: To create a community mental health clinic located in Grand Prairie to provide behavioral health services to the underserved in that area. Services will include psychiatric evaluations, pharmacy services, counseling, rehabilitation and skills training and case management. The type and volume of services provided to a client will be determined by information collected during the initial psychiatric evaluation, including patient reported needs on the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).

Need for the project: The Region 9 Community Assessment reports "an inadequate supply of behavioral health services is one of the most significant unmet health needs" of our area. Further, the RHP identifies the need for "development of lower levels of care in order to prevent the need for high-cost services" in our community. By operating an additional community based mental health clinic, Metrocare will expand access to behavioral health services to the underserved in Dallas County.

Target population: The mental health clinic will provide treatment services to children, youth, families and adults. Metrocare estimates that 56% of the people served through this clinic will be indigent patients and 44% of the clients served will be insured by Medicaid.

Category 1 or 2 expected benefits: The goals of this project include:

- Increase the number served of patients served each year (DY 2- 250, DY 3-500, DY 4-750, DY 5-1000)
- Increase the percentage of patients report satisfaction with services at Grand Prairie clinic (DY 3 – 70% / 350 clients, DY 4 – 75% / 563 clients, DY 5 – 80% / 800 clients) as measured by the Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Category 3 outcomes: The goals of this project include:

- DY 4 - 70% of patients served will report improved Quality of Life (IT-10.1) as measured by the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA)

- DY 4 – 80% of patients served will report improved Quality of Life (IT-10.1) as measured by the CANS and ANSA

Project Description

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

As identified in the Community Needs Assessment for Region 9, "an inadequate supply of behavioral health services is one of the most significant unmet health needs" of our area (Collins, 2012.RHP 9: Community Needs Assessment Report). To combat this ever growing problem, Metrocare Services will create an additional community mental health clinic located in Grand Prairie to provide mental health treatment to the underserved living in that area. The site will provide treatment services to children, youth, families and adults. To begin operations, the clinic will be staffed with one psychiatrist, registered nurse, pharmacist, pharmacist technician, licensed clinician, qualified mental health professional and business support staff. Treatment services offered at each clinic will include psychiatric evaluations, pharmacy services, counseling, rehabilitation and skills training and case management.

Collaboration

This project is being proposed through a collaboration agreement. The specific collaboration arrangement for this project is set forth below.

Collaborators	**DY2**	**DY3**	**DY4**	**DY5**	**Total**
Parkland Memorial Hospital	485,135	127,511	35,806	80,497	728,949
Project / Collaboration	**DY2**	**DY3**	**DY4**	**DY5**	**Total**
Category 2 Project Value	2,089,713	1,616,030	1,636,304	1,470,349	6,812,396
Related Category 3 Projects Value	179,550	181,812	367,587	728,949	427,821
Total Project Value	**2,269,263**	**1,797,842**	**2,003,891**	**2,199,298**	**7,240,217**

The collaboration involves the transfer of Pass 2 allocated dollars from Parkland Memorial Hospital (public entity) to the performing provider (public entity). The combined project value for this project exceeds the funding provided by the collaborating entity.

The collaborating parties have joined together in this collaboration with the belief that the goals of this project are valuable and will contribute to regional transformation.

Goals and Relationship to Regional Goals

The goal of this project is to expand underserved consumers' access to behavioral health services by opening a community outpatient clinic in Grand Prairie. By expanding access to treatment, these consumers increase their ability to participate in services in their community

and through these services may decrease the need for expensive interventions such as hospitalization, residential treatment and criminal justice involvement. The National Association of Mental Illness identifies that "lack of community services results in significantly overcrowded emergency rooms and inappropriate use of prisons as warehouses for people with mental illness" (NAMI, 2009. Grading the State 2009 Report: TX). Furthermore, the Region 9 Community Needs Assessment reports providers in Dallas County need to develop lower levels of care in order to prevent the need for high-cost services (Collins, 2012). There is a correlation between increased utilization of not only expensive behavioral health services, such as residential treatment, but also costly medical treatment including hospitalization when mental health issues are not treated. For Dallas County specifically, the presence of a "co-occurring behavioral health condition is associated with increased case severity of medical encounters and a 36% increase in the average charges per encounter" (Collins, 2012). Lastly, the North Texas Behavioral Health Authority conducted a survey and identified transportation as one of the major barriers to accessing needed services (Collins, 2012). By operating clinics in Grand Prairie, where there is no public transportation system, Metrocare is expanding access to thousands of potential clients who have historically struggled to receive services.

Challenges

According to a recent analysis of the Texas Public Behavioral Health System, Texas ranks last nationally among all states in mental health funding and relies too heavily upon a system of emergency services versus promoting recovery and prevention through a system of community based care (Public Consulting Group, 2011). Limited funding forces a behavioral health system to focus on crisis services to meet immediate need and does not allow for sufficient provision of preventive or maintenance care. Unfortunately, this focus on crisis intervention with limited follow up services creates an ineffective cycle where clients engage in services only when in crisis and do not participate in ongoing services that can aid a client to improve overall functioning and decrease dependency on those emergency services. Furthermore, the PCG (2011) acknowledges in its report that our reliance upon "spending millions of dollars in mental health and substance abuse services within the county jail and other law enforcement agencies is symptomatic of our inadequate community based system of care." Research conducted by the Texas Department of State Health Services (2010) found that many clients who received services outlined in a traditional RDM Service Package as a jail diversion strategy reported "clinical benefits including decreased risk of harm, decreased need for support, fewer psychiatric hospitalizations, decreased functional impairment, decreased employment problems, decreased housing instability, and decreased co-occurring substance abuse." Regarding children and adolescents, research reveals that "mental health services available to children are limited" and services "oftentimes do not include the family-focused and comprehensive approach needed to adequately address client issues" (Collins, 2012). In addition, the need for publicly funded mental health services for youth has grown significantly in the last 10 years with the majority of intensive services for youth provided by the juvenile justice system (Collins, 2012). The lack of early intervention and consistent treatment at the community level can result in expensive treatment that often involves separation from immediate family. Furthermore, research reveals that effective treatment for children must be

a comprehensive approach that addresses all areas of the child and family's lives; an intervention that is much easier and effectively implemented at a community level versus institutionalization (Blader, Joseph 2003).

Evidenced based research consistently demonstrates that community based outpatient care is a beneficial and cost effective therapeutic approach to treatment. By opening an additional clinic in an underserved area of Dallas County, Metrocare is helping to address the challenges identified here; enhancing access to behavioral health services that can improve quality of life and result in less dependence upon higher levels of care.

5-Year Expected Outcome for Provider and Patients

- Develop administrative protocols and clinical guidelines for new clinic
- Hire and train staff to operate and manage clinic
- Establish behavioral health services in new community-based clinic in underserved area
- Evaluate and continuously improve services
- Improved Consumer satisfaction with Access

Starting Point/Baseline

Baseline for measures is zero.

Rationale

The Region 9 Community Assessment reports "an inadequate supply of behavioral health services is one of the most significant unmet health needs" of our area (Collins, 2012). Further, the RHP identifies the need for "development of lower levels of care in order to prevent the need for high-cost services" in our community (Collins, 2012). The impact of scarce community based treatment is profound, influencing all aspects of a client's life and the greater community. To begin, unmet mental health needs greatly affect a person's ability to properly care for their medical needs and can result in increased cost to taxpayers for potentially preventable medical illnesses. For Dallas County, the presence of a "co-occurring behavioral health condition is associated with increased case severity of medical encounters and a 36% increase in the average charges per encounter (Collins, 2012). Lack of community based services also results in "significantly overcrowded emergency rooms" for people seeking crisis services and "inappropriate use of prisons as warehouses for people with mental illness" (NAMI, 2009). According to the Region 9 Community Assessment, 27% of all book-ins to Dallas County jail are currently referred to behavioral health services within the jail" (Collins, 2012). In addition, homeless individuals with behavioral health conditions "cost 3 times as much and are booked into jail 2 times as often as the general Northstar population" (Balfour, 2011). By providing case management services to clients in our community based clinics, Metrocare can assist consumers to stabilize and improve functioning; resulting in less dependence upon higher levels of care. Lastly, NTBHA identified transportation as one of the major barriers to

individuals accessing services (Collins, 2012); by launching a community based clinic in Grand Prairie, where there is no public transportation system, Metrocare will expand access to behavioral health services for potentially thousands of Dallas County residents.

The new clinic will serve children, youth and families in addition to adults. The need for publicly funded mental health services for youth has grown significantly in the last 10 years with the majority of intensive services for youth provided by the juvenile justice system (Collins, 2012). The lack of early intervention and consistent treatment at the community level can result in expensive treatment that often involves separation from immediate family. Furthermore, research reveals that effective treatment for children must be a comprehensive approach that addresses all areas of the child and family's lives; an intervention that is much easier and effectively implemented at a community level versus institutionalization (Blader, Joseph 2003). In summary, Metrocare Services is the largest provider of mental health services in Dallas County. We serve approximately 10,000 people diagnosed with a mental illness each month. By operating an additional community based mental health clinic, Metrocare will expand access to behavioral health services to the underserved in Dallas County. Evidence based research reveals the need for additional community based programs and outcomes demonstrate that these programs are effective and cost beneficial to the greater community. To ensure success towards our goal, Metrocare chose milestones and metrics that are relevant to project development; training of staff; operating the clinic; and continuously evaluating operations for expanding access and provision of quality services.

Project Components

There are no project components from Project Option 1.12.2

Unique community need identification numbers the project addresses

CN.5 – Behavioral Health
CN.6 – Behavioral Health and Primary Care
CN.7 – Behavioral Health and Jail Population

How the project is a significant enhancement to an existing delivery system reform initiative

This project will significantly enhance access to behavioral health services by expanding the number of community based settings in an underserved area in Dallas County.

Related Category 3 outcome measure

- IT 10.1 Quality of Life/Functional Status

The Category 3 Improvement Target regarding improved quality of life/functional status (IT 10.1) is the related improvement outcome to this project. By measuring a patient's improved quality of life, Metrocare will assess the effectiveness of the services offered at the clinic in

assisting the client to meet his/her treatment goals. The Child and Adolescent Needs and Strengths Assessment and the Adult Needs and Strengths Assessment were chosen as the standardized tools to measure Quality of Life as both tools have demonstrated reliability and validity and will allow Metrocare to monitor for progress towards improved quality of life throughout a client's participation in services.

Relationship to Other Projects

This project is one element of the behavioral health services continuum of care and relates to all other projects that provide/enhance behavioral services:

137252607.1.1	Metrocare – Workforce Enhancement
137252607.2.1	Metrocare – Integrate primary care and behavioral health
137252607.2.2	Metrocare – ACT (Assertive Wrap-around Program)
137252607.2.3	Metrocare – Family Preservation
137252607.2.4	Metrocare – Center for Children with Autism
137252607.2.5	Metrocare – Day Program

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

Learning Collaborative - We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV-Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Metrocare Services determined the value of each project by comparing the budgeted cost of the specific project against the cost to the community should the services go unprovided. Costs associated with emergency room visits, hospitalization, arrest, detention and residential treatment were factors in determining the value of this project. It is estimated that participation in outpatient services, as defined as minimum of three months of consecutive treatment, will result in less than 20%of those served seeking higher levels of care for psychiatric needs or involved in the criminal justice system. Metrocare will collaborate with Parkland Hospital regarding the referral of individuals for behavioral health services. The Center will also be an active member in community initiatives for the learning collaborative.

Endnotes/References

1. Balfour, M.E. (2011) "Homelessness, Criminal Justice and the NorthStar Top 200 Report"

2. Blader, Joseph. (2003) “Symptom, Family and Service Predictors of Children’s Psychiatric Rehospitalization within One Year of Discharge.” Journal of American Academy of Child and Adolescent Psychiatry
3. Collins, S. (2012) Regional Healthcare partnership 9: Community Needs Assessment Report
4. National Association of Mental Illness (2009) “Grading the State 2009 Report: Tx”
5. Public Consulting Group (2011) “Analysis of the Texas Public Behavioral Health System”
6. Texas Department of State Health Services (2010) “Another look at Mental Illness and Criminal Justice Involvement in Texas: Correlates and Costs”

137252607.1.2	*Project Option: 1.12.2*	*Project Components: NA*	*Expansion of Behavioral Health Outpatient Services to Children, Families and Adults*
Dallas County MHMR Center dba Metrocare Services			*137252607*
Related Category 3 Outcome Measures	*137252607.3.12*	*IT-10.1*	*Quality of Life/Functional Status*

Year 2 (10/1/2012-9/30/2013)	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 administrative protocols and clinical guidelines for new clinic **Metric 3.1:** Manual of operations for the clinic detailing administrative protocols and clinical guidelines **Goal**: Develop Manual of Operations **Data Source**: Metrocare administrative protocols and clinical guidelines **Milestone 1 Estimated Incentive Payment: $696,571** **Process Milestone 2** P-4 Hire and train staff to operate and manage clinic **Metric 4.1 :** Number of staff secured and trained **Baseline:** 0 **Goal:** Hire and train one Prescriber, Nurse, Pharmacist, Pharmacist Technician, LPHA, QMHP, Business Support Staff and Financial Services	**Process Milestone 4** P-6 Establish behavioral health services in new community-based clinic in underserved area **Metric 6.1:** One new community based setting where behavioral health services are delivered **Baseline:** 250 **Goal:** To serve 500 clients at the Grand Prairie Clinic **Data source:** Metrocare Clinical System **Milestone 4 Estimated Incentive Payment: $538,676** **Process Milestone 5** P-7 Evaluate and continuously improve services **Metric 7.1:** Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles **Goal:** Use real time data for rapid-cycle improvement to guide continuous quality improvement	**Process Milestone 6** P-4 Hire and train staff to operate and manage clinic **Metric 4.1 :** Number of staff secured and trained **Baseline:** 1 Prescriber, Nurse, Pharmacist, Pharmacist Technician, LPHA, QMHP, Business Support Staff and Financial Services Staff **Goal:** Hire and train one additional Prescriber, Nurse, Pharmacist Technician, LPHA, QMHP, Business Support Staff and Financial Services staff **Data Source**: Metrocare Manual of Operations including clinical guidelines and business support procedures **Milestone 6 Estimated Incentive Payment: $409,076** **Process Milestone 7** P-6 Establish behavioral health services in new community-based clinic in underserved area **Metric 6.1:** One new community based setting where behavioral health services are delivered	**Process Milestone 9** P-6 Establish behavioral health services in new community-based clinic in underserved area **Metric 6.1:** One new community based setting where behavioral health services are delivered **Baseline:** 750 **Goal:** To serve 1000 clients at the Grand Prairie Clinic **Data source:** Metrocare Clinical System **Milestone 9 Estimated Incentive Payment: $490,117** **Process Milestone 10** P-7 Evaluate and continuously improve services **Metric 7.1:** Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles **Goal:** Use real time data for rapid-cycle improvement to guide continuous quality improvement **Data Source:** Metrocare Clinical Data

137252607.1.2	*Project Option: 1.12.2*	*Project Components: NA*	*Expansion of Behavioral Health Outpatient Services to Children, Families and Adults*
Dallas County MHMR Center dba Metrocare Services			*137252607*
Related Category 3 Outcome Measures	*137252607.3.12*	*IT-10.1*	*Quality of Life/Functional Status*

Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/2013-9/30/2014)**	**Year 4 10/1/2014-9/30/2015)**	**Year 5 10/1/2015-9/30/2016)**
staff **Data Source**: Metrocare Manual of Operations including clinical guidelines and business support procedures **Milestone 2 Estimated Incentive Payment: $696,571** **Process Milestone 3** P-6 Establish behavioral health services in new community-based clinic in underserved area **Metric 6.1:** One new community based setting where behavioral health services are delivered **Baseline:** 0 **Goal:** To serve 250 clients at the Grand Prairie Clinic **Data source:** Metrocare Clinical System **Milestone 3 Estimated Incentive Payment: $696,571**	**Data Source:** Metrocare Clinical Data System and Quality Management Department **Milestone 5 Estimated Incentive Payment: $538,676** **Improvement Milestone1** I-14 Improved Consumer satisfaction with Access **Metric I-14.1:** Numerator: number of people receiving services through expanded access site that have expressed satisfaction with services Denominator: number of individuals receiving services through expanded access site **Goal:** 70% (350 clients) of those served through expanded services will report satisfaction with services. **Data Source:** CAHPS, Metrocare Clinical Data **Improvement Milestone 1 Estimated Incentive Payment: $538,676**	**Baseline:** 500 **Goal:** To serve 750 clients at the Grand Prairie Clinic **Data source:** Metrocare Clinical System **Milestone 7 Estimated Incentive Payment: $409,076** **Process Milestone 8** P-7 Evaluate and continuously improve services **Metric 7.1:** Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles **Goal:** Use real time data for rapid-cycle improvement to guide continuous quality improvement **Data Source:** Metrocare Clinical Data System and Quality Management Department **Milestone 8 Estimated Incentive Payment: $409,076** **Improvement Milestone 2** I-14 Improved Consumer satisfaction with Access	System and Quality Management Department **Milestone 10 Estimated Incentive Payment: $490,116** **Improvement Milestone 3** I-14 Improved Consumer satisfaction with Access **Metric I-14.1:** Numerator: number of people receiving services through expanded access site that have expressed satisfaction with services Denominator: number of individuals receiving services through expanded access site **Goal:** 80% (800 clients) of those served through expanded services will report satisfaction with services. **Data Source**: CAHPS, Metrocare Clinical Data **Improvement Milestone 3 Estimated Incentive Payment: $490,116**

137252607.1.2	*Project Option: 1.12.2*	*Project Components: NA*	*Expansion of Behavioral Health Outpatient Services to Children, Families and Adults*
Dallas County MHMR Center dba Metrocare Services			*137252607*
Related Category 3 Outcome Measures	*137252607.3.12*	*IT-10.1*	*Quality of Life/Functional Status*

Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/2013-9/30/2014)**	**Year 4 10/1/2014-9/30/2015)**	**Year 5 10/1/2015-9/30/2016)**
		Metric I-14.1: Numerator: number of people receiving services through expanded access site that have expressed satisfaction with services Denominator: number of individuals receiving services through expanded access site **Goal:** 75% (563 clients) of those served through expanded services will report satisfaction with services. **Data Source:** CAHPS, Metrocare Clinical Data **Improvement Milestone 2** **Estimated Incentive Payment:** **$409,076**	
Year 2 Estimated Milestone Bundle Amount (add incentive payment amounts from each milestone): $2,089,713	Year 3 Estimated Milestone Bundle Amount: $1,616,030	Year 4 Estimated Milestone Bundle Amount: $1,636,304	Year 5 Estimated Milestone Bundle Amount: $1,470,349
TOTAL ESTIMATED INCENTIVE PAYMENT FOR 4-YEAR PERIOD: $6,812,396			

Project Option 1.13.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization (Crisis Respite Behavioral Support Wraparound Program)

Unique Project ID: 121988304.1.1
Performing Provider Name/TPI: Lakes Regional MHMR Center/121988304

Provider: Lakes Regional MHMR Center is a community-based provider of out-patient services to adults with serious mental illness, chemical dependency; to children and adolescents with serious mental illness or emotional disorders; to persons with autism, pervasive developmental disorders or intellectual disabilities; and to infants and toddlers with developmental delays. Lakes Regional MHMR Center's service area includes 12 Texas counties with a total population of 633,045 and spans an area of 6,762 square miles. The service area crosses four Regional Healthcare Partnership (RHP) areas and is mostly rural. Lakes Regional's community programs serve 9,500+ individuals each year and 95% of our consumers are Medicaid eligible or indigent.

Intervention(s): Lakes Regional will develop a behavioral health crisis stabilization service for dually diagnosed individuals with intellectual/developmental disabilities, autism spectrum disorders and behavioral health needs as an alternative to hospitalization, including a crisis respite facility, and wraparound services to serve Kaufman County and surrounding counties. This project intervention is new: there are no other alternative crisis stabilization services or wraparound services for the targeted population in the proposed service area.

Need for the project: There is currently a lack of provider capacity that will serve the Medicaid and indigent population for these behavioral health and other specialty services. The region is looking for ways to feasibly and effectively improve provider capacity and access to crisis alternative services (specialists) for remote populations/ communities. Our project is focused on the provision of crisis respite with wraparound services, and health and wellness services for the target population (low income, rural areas of Kaufman and surrounding counties). Currently there is no community-based crisis alternative service in this region, which leads to overuse of emergency departments, hospital and institutional settings unnecessarily.

Target population: The target population is dually diagnosed individuals with intellectual/developmental disabilities, autism spectrum disorders and/or behavioral health needs, who require specialty consultation (i.e., psychiatry, certified behavioral analysts, counseling, nursing, therapy, and other specialty services consults). We estimate serving a minimum of 250 clients over the waiver period. Approximately 95% of our patients are either Medicaid eligible or indigent, so we expect they will benefit from the availability of crisis alternative services.

Category 1 or 2 expected patient benefits:
The benefits include improved patient outcomes such as reducing recidivism and unnecessary ED visits. Wrap Around Behavioral Support Services will utilize a multi-disciplinary treatment team model to provide interventions that will increase the individual's ability and likelihood to deescalate effectively during crisis; particularly when those interventions are provided in a

natural and less restrictive environment. Process milestones listed for the project are designed to establish baseline need for a crisis services alternative in the region, to gather data on the current community crisis system and to design a program that is tailored to the needs of the target population with IDD/ASD/MH. The expected patient benefit will reduce the use of services that have limited or no abilities to provide Dual Diagnosis (IDD/MH) treatment. The project seeks to minimally serve 250 dually diagnosed individuals in DY4 and DY5.

Category 3 outcomes: IT-6.1 The project goal is to achieve a 60% improvement overall by DY5 in patient satisfaction with health status/functional status related to improving access to care, quality of care, and health outcomes, as well as improving overall health for the target population.

Project Description

Lakes Regional will develop a behavioral health crisis stabilization service as an alternative to hospitalization by establishing a community-based program to provide a continuum of services, including a crisis respite facility, and wraparound services to serve Kaufman and surrounding counties. The program will include an intensive and interdisciplinary behavioral response team to provide comprehensive wraparound services and interventions to high risk clients who are dually diagnosed with Intellectual and Developmental Disabilities/Autism Spectrum Disorder and Mental Health diagnosis (IDD/ASD/MH), or have other co-occurring disorders and/or medical needs. These interventions will involve developing and implementing crisis stabilization services to address the identified gaps in the current community crisis system. By developing crisis/respite residential treatment, individuals in crisis will receive appropriate, cost effective care at the right time and the right place by specialty behavioral health providers. Based on assessed levels of need and risk, the team would provide in-home consultation, specialty psychiatric services/telemedicine, skills training, family education, treatment planning, monitoring and referrals to needed services to ensure that high risk individuals remain in the least restrictive environment in the community. In addition, a Crisis Respite Treatment site would be established to stabilize referred individuals in crisis or in danger of out of home placement and/or psychiatric hospitalization. A key component of this project is extensive on-going training in Applied Behavioral Analysis to team members/caregivers and significant others to avoid acute crisis events and assist in stabilizing individuals in their home. The team will receive training in providing culturally competent care, and interpretation services would be available and transportation, as needed.

Goals and Relationship to Regional Goals

The goals of this project are: 1) to improve access to appropriate crisis alternatives by providing a crisis stabilization program with wraparound services, including the availability of translation and transportation services; 2) to improve patient satisfaction with physical and behavioral health outcomes through the use of early intervention and intensive wraparound services. Presently there is no short term crisis respite or clinic in this rural county (Kaufman) in Region 9 that offers comprehensive wraparound services for the IDD/ASD/MH populations.

The project relates to the Region 9 goals to improve access to behavioral health services and to reduce the unnecessary use of Emergency Department services (CN.5, CN.7, CN.12) The project relates to improving access to care and improving overall quality of care for the targeted safety net population, and lowering cost of care by decreasing emergency department services.

Challenges

Based on a recent Stakeholder meeting, participants noted a significant and costly delay in moving individuals from the State Psychiatric Hospital into the community. Additional feedback indicated that individuals who are dually diagnosed experience barriers to care in more structured settings due to the status of being dually diagnosed with IDD/MH. Reportedly there is a significant and costly delay in the time it takes for an individual in crisis to be assessed by behavioral health crisis teams, and in some circumstances, not being assessed at all due to their dually diagnosed status. In this geographic rural area crisis teams are not always available on a timely basis. The Stakeholders also identified the lack of availability of care before 8 am and after 5 pm a significant barrier to access to care.

The 2010 Annual Survey of Hospital Tracking Data for Kaufman County listed 32,086 Emergency Department visits respectively. A number of these ER visits may have included the specialty population targeted by this project. Kaufman County is designated as an official Mental Health Professional Shortage Area[106]. The region lacks key community-based alternatives to costly and unnecessary emergency commitments and ED visits for the target population, while 24% of the population in the region reports having had a mental health occurrence related to stress or depression lasting longer than 5 days, and 40% making less than $25,000 per year in the region. 31.5% of African Americans and nearly 30% of Hispanics in the region are reportedly vulnerable to behavioral health risk factors[107]. The project will target IDD/ASD/MH individuals at risk for high utilization of ER services due to behavioral challenges and divert them to a community-based crisis alternative service at half the cost of hospitalization or institutionalization[108]. Stakeholders also identified post-jail care is not available or delayed which increases the rate of recidivism.

5-Year Expected Outcome for Provider and Patients

The 5 year expected outcome of this project is to provide an increase in utilization of appropriate crisis alternative in DY5 by 250 individuals. The expected result will be a significant decrease in preventable behavioral health events that typically result in hospitalization, incarceration and institutional care for individuals with IDD by deescalating crises in the natural environment with Wrap Around Behavior Support Services. The patient benefit is the promotion of self-management of challenging behaviors for the target population in the community, and significant reductions in the overall cost of care by utilizing a seamless system

[106] http://bhpr.hrsa.gov/shortage/
[107] http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?pageid=35474
[108] http://www.ncbi.nlm.nih.gov/pubmed/8678177, Day Hospital/Crisis Respite Care vs. Inpatient Care, Am J Psychiatry. 1996 Aug; 153(8):1074-83.

of care. The availability of nursing services within the crisis-respite team will facilitate integrated care to address fragmentation and discontinuity of health care, resulting in improvement of patient satisfaction and outcomes[109] Research has shown that the use of Intensive Case Management reduced the number, confidence interval and duration of inpatient admissions, reducing the number of reported needs and increasing patient satisfaction, as well as the cost of care borne by the health sector[110]. The outcome will be improvement in overall life satisfaction and ability to live independently for the target population/service recipients.
Projected patient impact by DY is as follows:
DY2 – Stakeholders will benefit from availability of an analysis of community needs for crisis services with identified gaps in the current system.
DY3 – Stakeholders will benefit from a program designed to tailor to the crisis needs of the identified population in the local community.
DY4 – 100 individuals will have access to utilization of appropriate crisis alternatives in the community.
DY5 – 150 additional individuals will have access to utilization of appropriate crisis alternatives in the community.

Starting Point/Baseline

Number of clients –The baseline for the project is to be established, since it will be a new program. The target population includes individuals (children and adults) in Kaufman County with IDD and co-occurring, mental and behavioral disorders. There are currently approximately 1100 individuals being served in this county by the public MH provider and by the IDD Local Authority. Additionally, more than 200 IDD individuals are currently being served by private waiver providers in the target area, creating a sizable potential ongoing target population for the project. With the addition of referrals from school districts, and Community Resource Coordination Groups (CRCGs), the number of targeted individuals to be served potentially in the program is 250 for the various program interventions within the project scope over the waiver period. Lakes Regional's internal data indicates that approximately 65% IDD/ASD-diagnosed clients in their counties have a psychiatric diagnosis, or receive psychotropic medication for psychiatric symptoms. Currently we have one provider trained in the project; a board certified behavior analyst (BCBA). The project calls for 12 additional professional staff to be hired.

Rationale

According to the RHP Protocol, "when a consumer lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the

[109] Jansen, D., Krol, B., Groothoof, J. and Post., D. (2006). Towards improving medical care for people with intellectual disability living in the community: possibilities of integrated care. *Journal of Applied Research in Intellectual Disabilities.* 19: 214-218.
[110] Hassiotis. A. (2002). Community mental health services for individuals with intellectual disabilities: issues and approaches to optimizing outcomes. *Disability Management and Health Outcomes* 10 (7): 409-417.

situation. Sometimes the choice comes down to the ER, jail or an inpatient hospital bed. Crisis stabilization services can be developed that create alternatives to these less desirable settings"

For the IDD/ASD/MH population, this problem is intensified due to an even greater limitation on settings that are available and appropriate for managing crisis. Kaufman County is designated as an official Mental Health Professional Shortage Area, and MHMR Centers are lacking provider capacity, as well as staff trained in providing culturally competent care with over 40% of the population in the region being African American or Hispanic. With the opportunity to develop behavioral health crisis stabilization services the target population will:

- Receive behavioral health management interventions through the provision of comprehensive wraparound services;
- Have access to a community-based interdisciplinary intensive behavior supports response team hired and trained in cultural competence to decrease barriers to care;
- Have access to nursing services within the crisis/respite team in addition to a psychiatrist, improving physical and mental health outcomes;
- Have access to early intervention and crisis services, enabling them to be better equipped for crisis situations, thus avoiding unnecessary and costly ED visits and inpatient treatment.

Project Components

Currently there is no community-based crisis alternative service in this region. To determine the need and appropriateness of the intervention, the project involves these core components:

a) Convening community stakeholders to conduct a gap analysis of the current community crisis system, and to develop a specific action plan to address the identified gaps -- this will allow the project to establish a baseline of need
b) Analysis of the current system of crisis stabilization services available in the community – this will allow the project to establish a baseline of need and design of a program that fits the needs of the target population in the local area;
c) Assessing the behavioral health needs of the target population with IDD/ASD/MH currently receiving crisis services in a variety of settings to:
    - Determine types/volume of services needed to resolve crises in community-based settings
    - Conduct gap analysis that results in a data-driven plan to tailor community-based crisis stabilization alternative services to the needs of the target population.
d) The project has identified the community-based crisis respite model with wraparound services, including telepsychiatry, nursing services, BCBA services, service coordination, community supports/skills training, short-term day habilitation, assertive community

treatment (ACT) and intensive case management, which are an evidence-based practice that ensures medication and treatment adherence, and links the patient with resources[111]. The wraparound crisis and ACT model is a highly researched evidenced approach for delivering behavioral health services; it is listed in the Texas Administrative Code, Community Standards, and Best Practices.

e) The project will also involve sharing and disseminating findings to other agencies, providers and stakeholders in the region, including: reviewing the impact of selected evidence-based interventions on access to and quality of behavioral health crisis stabilization services, as well as lessons learned and key challenges in expanding the interventions to a broader population.

Rationale for selecting outcome measures

Process milestones listed for the project are designed to establish baseline need for a crisis services alternatives in the Region, to gather data on the current community crisis system and to design a program tailored to the needs of the target population with IDD/ASD/MH.
Process milestones also encompass hiring of staff and creation of policies and procedures prior to program implementation. Improvement milestones address measurement of an incremental increase in utilization of the program in DYs 4 and 5. Metrics in DYs 4 and 5 will measure an increase in utilization of the program by a minimum of 250 individuals at the completion of DY5.

Specify the unique community need identification number the project addresses:

CN.5 - Behavioral Health
CN.7 – Behavioral Health and Jail Population
CN.12 – Emergency Department Usage and Readmissions

How the Project represents a new initiative

This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

IT-6.1 Percent improvement over baseline of patient satisfaction scores measuring patient's overall health status/functional status. (Stand-alone)
Research has shown that there is a much greater instance of health problems in the IDD population[112]; the program staff will monitor mental and physical health status and outcomes

[111] Kolbasovsky, A., Reich, L, Meyerkopf, N. (2010). Reducing six-month inpatient psychiatric recidivism and costs through case management. *Care Management Journals* 11: 2-10. DOI; 10. 1891/1521-0987. 11.1.2.
[112] Jansen, D., Krol, B., Groothoff, J. and Post, D. (2004). People with intellectual disabilities and their health problems: a review of comparative studies. *Journal of Intellectual Disability Research* 48 (2): 93-102.

to facilitate integrated care, improvement of patient satisfaction and outcomes for the target population[113]. Research has shown that the use of Intensive Case Management reduced the number, confidence interval and duration of inpatient admissions, reducing the number of reported needs and increasing patient satisfaction, as well as the cost of care borne by the health sector[114]. These projected outcomes relate to improving access to care, quality of care, and health outcomes, as well as improving overall health for the target population. The CG-CAHPS survey produces ". . . comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers"[115]. Sharing survey results with other agencies and providers in the region regarding consumer satisfaction with overall health and functional status will bring about improvements in the overall health system for individuals with IDD/ASD/MH; sharing survey results with stakeholders will result in a greater awareness of the efficacy of the crisis respite wraparound model in improving life satisfaction, following better self-management skills and follow-up to care.

Relationship to Other Projects:

1.7 Telemedicine Project – The Lakes Regional telemedicine project will allow access to remote provider services, psychiatric counseling and primary care services. Telemedicine technology will be utilized as an integral focus of the provision of care proposed in the Crisis Stabilization project.
Related Category 4 Population-focused improvements: N/A

Relationship to Other Performing Providers' Projects and the Plan for Learning Collaborative
Our agency will play an active role in the development and ongoing conduct of Project Learning Collaborative, appropriate to our project, as organized by RHP 9 and described in Section IV-Stakeholder Engagement. We also will participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that will enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project. Tarrant County MHMR is proposing a similar project to the same target population for Crisis Avoidance; Pecan Valley MHMR is also providing crisis respite as an aspect of a project in collaboration with their internal behavioral health provider. Lakes Regional has been participating in collaborative teleconference calls with the other MHMR providers in various regions to share resources and best practices surrounding this expansion, and will propose to continue this collaboration in some capacity pending project funding and implementation.
With our established network of support to share resources, Lakes Regional proposes to further

[113] Jansen, D., Karol, B., Groothoof, J. and Post D. (2006). Towards improving medical care for people with intellectual disability living in the community: possibilities of integrated care. *Journal of Applied Research in Intellectual Disabilities.* 19: 214-218
[114] Hassiotis. A. (2002). Community mental health services for individuals with intellectual disabilities: issues and approaches to optimizing outcomes. *Disability Management and Health Outcomes* 10 (7): 409-417.
[115] RHP Planning Protocol, Attachment 1, 398

this collaboration in some capacity pending project funding and implementation and develop collaborations with private providers, correctional and emergency departments in the region.

Project Valuation

Currently, there is no community-based alternative crisis service for the dually diagnosed IDD/ASD/MH target population (children and adults) in Kaufman County. This project is designed to enhance the quality of life of individuals in the target population by providing culturally competent wraparound services to 1)improve access to appropriate crisis alternatives in the community by providing a crisis stabilization program with wraparound services (including the availability of translation and transportation services); 2) improve patient satisfaction with behavioral health and physical health outcomes for the target population through intensive wraparound services and 3) decrease unnecessary utilization of ED and higher levels of care, reducing overall cost of care. These goals will be accomplished via the collaborative involvement of providers in the public behavioral health system, private waiver providers, physical health and the developmental disabilities service system, resulting in potentially a significant decrease in preventable behavioral health events that typically result in hospitalization, incarceration and institutional care for the target population. The anticipated valuation addresses a priority need in the community that allows for cost avoidance, supporting individuals in the community at a lesser cost than institutional care, avoiding costs in emergency rooms, psychiatric hospitals and the criminal justice system. The project also addresses the barrier to care related to lack of transportation in a large, primarily rural geographic area by providing access to transportation to critical community resources.
Size factor: There are currently approximately 1100 individuals with IDD being served in these counties by the public MH provider and by the IDD Local Authority. Currently there is no crisis respite alternative program in the Region 9 area. With 30 to 35% of IDD individuals estimated to have a psychiatric disorder and with the additional projection of 200 IDD individuals being served by private waiver providers in the target area, the number of targeted individuals to be served potentially in the program would be a minimum of 250 over the waiver period. Performing providers in Region 9 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 9 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Lakes Regional MHMR has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B. In addition, this project was valued based on studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: "Valuing the Program to Create an Assertive Community Treatment (ACT) Team for People with Intellectual and Developmental Disabilities (IDD)" and "Valuing the Crisis Respite for Children Program." These studies were completed through a contract with Center for Health Care Services. These valuation studies used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency room visits that are avoided). Complete write-up of project research is available at provider site.

Total valuation of project is $6,421,691.

121988304. 1.1	*1.13.1*	*1.13.1 (A-E)*	*DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION - CRISIS RESPITE BEHAVIORAL SUPPORT WRAPAROUND PROGRAM*	
Lakes Regional MHMR Center				*TPI: 121988304*
Related Category 3 Outcome Measure(s):	*121988304.3.1*	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status.*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and Psychiatric hospitals, EMS, and relevant community behavioral health services providers. Metric 1 [P-1.1]: Number of meetings and participants Baseline/Goal: Meeting 1x/month Data Source: Attendance lists Milestone 1 Estimated Incentive Payment: $766,476 **Milestone 2** [P-2] Conduct mapping and gap analysis of current crisis system. Metric 1 [P.2.1]**:** Produce written analysis of community needs for crisis services. Baseline/Goal: Gaps in the current crisis system and community need for crisis services identified. Data Source: Written plan Milestone 2 Estimated Incentive Payment: $766,477		**Milestone 3** [P-4] Hire and train staff to implement identified crisis stabilization services. Metric 1 [P-4.1]**:** Number of staff hired and trained Baseline/Goal: Hire staff Data Source**:** Staff rosters and training records; training Curricula Milestone 3 Estimated Incentive Payment: $727,537 **Milestone 4 [P-5]** Develop administration of operational protocols and clinical guidelines for crisis services. Metric 1 [P-5.1]**:** Completion of policies and procedures. Baseline/Goal: Operational protocols and clinical guidelines developed and begin services for referred individuals. Data Source**:** Internal Policy and Procedures documents and Operations manual, Patient records. Milestone 4 Estimated Incentive Payment: $727,537	**Milestone5** [I-12] Increase utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives by 50 individuals. Baseline= 0 Goal: Increase in utilization of appropriate crisis alternatives measured by 50 persons served in first 6 months of DY-4. Data Source: Patient records and # of encounters. Milestone 5 Estimated Incentive Payment: $880,835 **Milestone 6** [I-12] Increase utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives by 50 additional individuals. Goal: Increase in utilization of appropriate crisis alternatives measured by 50 additional individuals served in 2nd 6 months of DY-4. Data Source: Patient records and # of encounters. Milestone 6 Estimated Incentive	**Milestone 7** [I-12] Increase utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives by 75 additional individuals. Goal: Increase in utilization of appropriate crisis alternatives measured by 75 persons served in first 6 months of DY-5. Data Source: Patient records and # of encounters. Milestone 7 Estimated Incentive Payment: $836,027 **Milestone 8** [1-12] Increase utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives by 75 additional individuals. Served in 2nd 6 months of DY-5. Goal: Increase in utilization of appropriate crisis alternatives measured. Data Source: Patient records and # of encounters.

121988304. 1.1	*1.13.1*	*1.13.1 (A-E)*	*DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION - CRISIS RESPITE BEHAVIORAL SUPPORT WRAPAROUND PROGRAM*	
Lakes Regional MHMR Center				*TPI: 121988304*
Related Category 3 Outcome Measure(s):	*121988304.3.1*	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status.*	
Year 2 (10/1/2012 – 9/30/2013)		**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: $880,835	Milestone 8 Estimated Incentive Payment: $836,027
Year 2 Estimated Milestone Bundle Amount: **$1,532,953**		Year 3 Estimated Milestone Bundle Amount: **$1,455,074**	Year 4 Estimated Milestone Bundle Amount: **$1,761,610**	Year 5 Estimated Milestone Bundle Amount: **$1,672,054**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* **$6,421,691**				

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

Unique Project ID: 121988304.1.2
Performing Provider Name/TPI: Lakes Regional MHMR Center/121988304

Provider: Lakes Regional MHMR Center is a community-based provider of out-patient services to adults with serious mental illness, chemical dependency; to children and adolescents with serious mental illness or emotional disorders; to persons with autism, pervasive developmental disorders or intellectual disabilities; and to infants and toddlers with developmental delays. Lakes Regional MHMR Center's service area includes 12 Texas counties with a total population of 633,045 and spans an area of 6,762 square miles. The service area crosses four Regional Healthcare Partnership (RHP) areas and is mostly rural. Lakes Regional's community programs serve over 9,500 individuals each year Over 95% of our consumers are either Medicaid eligible or indigent.

Intervention: This project will implement telemedicine and telehealth services to provide consultations and increase capacity for behavioral health and other specialty provider services to the Medicaid and indigent target population.

Need for the project: There is currently have a lack of provider capacity that will serve the Medicaid and indigent population for these behavioral health and other specialty services. The region is looking for ways to feasibly and effectively improve provider capacity and access to services (specialists) for remote populations/ communities. Our project is focused on the expansion of behavioral health services (psychiatric and behavioral specialists), and health and wellness services for the target population (low income, rural areas of Rockwall County).

Target population: The target population consists of our clients needing specialty consultation (i.e., psychiatry, certified behavioral analysts, counseling, nursing, therapy, and other specialty services consults. Approximately 95% of our patients are either Medicaid eligible or indigent, so we expect they will benefit from the majority of the consults. We estimate that Lakes Regional will serve 210 patients over the course of the waiver period. This project will provide access to services (specialists) for remote populations/communities specifically targeting these services to Medicaid and indigent clients in rural areas of Kaufman County.

Category 1 or 2 expected patient benefits: The project seeks to provide for a minimum of 210 individuals for telemedicine e-consultations with a specialist over the course of the waiver and to maintain an annual increase tend of 40% (over baseline) for the numbers of patients served.

Category 3 outcomes: IT-6.1 Patient Satisfaction
The projected outcomes relate to an improvement in patient satisfaction and functional status. By the end of the waiver, our goal is to achieve 60% improvement overall by DY5 in patient satisfaction with health status/functional status related to improving access to care, quality of care, and health outcomes, as well as improving overall health for the target population.

Project Description

There currently exists a significant gap in behavioral health (psychiatric specialist referral services), and health and wellness services being provided in many Texas counties. Included among the listed counties is Kaufman and as of March 25th, 2011, these counties have been Federally Designated as Mental Health Professional Shortage Areas[116] . Lakes Regional MHMR Center proposes to reduce this gap and significantly improve patient access to these services (identified as needed in the Region for Kaufman County) with the implementation of telemedicine/telehealth technology. This technology uses electronic information and telecommunications to support a wide array of clinical health care services over long distance. These services include specialist referral services such as psychiatric care, patient and professional health-related education, and public health and administration. This approach in providing access to these services is a cost effective alternative to face to face communication, especially for individuals in remote/rural areas where access is difficult and/or unavailable. The planned telemedicine/ network technology for this project will include the deployment of high definition video/audio equipment, Virtual Private Network (VPN) internet cloud based connectivity and server based video session management technology. Server based telemedicine/ telehealth technology will allow for the management of multiple client/specialist sessions and the internet cloud connectivity will enable sessions between many different provider sites and mobile devices. The implementation plan includes quality improvement measures and "lessons learned" approach to making corrections and improvements to the program. Quality control methodologies and data analysis will be utilized to effectively manage the expansion of the program to the service areas where the population has the greatest need. Successful implementation of this technology will open the door for Lakes Regional to provide more flexible and timely delivery of needed health care and specialist services to individuals in rural areas of Kaufman County.

Goals and Relationship to Regional Goals

Specific goals for this project include: 1.) Successful planning and implementation of a telemedicine/ telehealth infrastructure program to provide and enable expansion of behavioral health services (including psychiatric specialist referral services), and health and wellness services with improved, flexible, and cost effective access to these services needed in Kaufman County. 2.) Continuous improvement in the quality of the technical functionality and processes of the telemedicine/telehealth system with a program of monitoring and analysis of the delivery system performance. 3.) Measurable and continuing improvement in the clinical processes of the telemedicine/telehealth program with clinical data tracking and analysis to show the expansion of access to specialty services, improvement in clinical outcomes, increasing patient satisfaction with the services they receive, and a 40% annual increase trend (DY4, DY5) for the number of individuals served and seeing a specialist over the DY3 established start-up baseline.

[116] U.S. Department of Health and Human Services Shortage Designation Branch (http://bhpr.hrsa.gov/shortage/)

As of March 25th, 2011, Kaufman has been identified (along with other counties in Texas) as Federally Designated as Mental Health Professional Shortage Areas[117]. Lakes Regional MHMR Center would like to close this gap and significantly improve patient access to these needed services with the implementation of telemedicine/telehealth technology. Lakes Regional is confident that the implementation of telemedicine/telehealth technology will work exceedingly well for the expansion of behavioral health services (including psychiatric specialists), and health and wellness services needed in Kaufman County. A needs assessment/ services gap analysis (our first project process-milestone) will be conducted to provide the information necessary for Lakes Regional to determine infrastructure requirements and the appropriate types and level of services (specialists and others) needed for the region and a successful telemedicine/telehealth start-up and expansion program.

The region is looking for ways to feasibly and effectively improve provider capacity and access to services (specialists) for remote populations/ communities. Our project is focused on the expansion of behavioral health services (psychiatric specialist), and health and wellness services for the target population (low income, rural areas of Kaufman County. By improving services access, quality of care and the clinical outcomes, the region anticipates a reduction in emergency room utilization and an overall cost savings for the region. Our telemedicine/ telehealth project will implement a means to move past current barriers towards helping the region achieve these goals. Lakes Regional has already successfully improved access and reduced costs by utilizing this technology in some of the larger clinics and with this experience will move the technology into the region for the more rural areas of Kaufman County. The application of this technology is very flexible and will provide the means to achieve changing service provider objectives for the region as the current needs for these communities are assessed. The program will allow connectivity between all kinds of service providers including doctors' offices, hospitals, specialty clinics, law enforcement and crisis care providers such as respite clinics with wrap-around services for IDD (another Lakes Regional implementation project). According to several studies[118], there have been upwards of 50 different medical subspecialties successfully served via telemedicine and the number is growing. These new services will help to reduce emergency room visits and the need for hospitalization by getting crucial /crisis care and preventative care where it is needed in the region.

Challenges

The use of telemedicine/telehealth technology for the expansion of behavioral health services (including psychiatric specialists), and health and wellness services has not yet been fully explored by Lakes Regional in Kaufman County. The number of individuals in need of specialist psychiatric and other services in the more remote penetration area around current Lakes Regional offices has not been established. A thorough needs assessment/services gap analysis (our first project process-milestone) will be conducted to provide the information necessary to

[117] U.S. Department of Health and Human Services (http://hpsafind.hrsa.gov/)
[118] American Telemedicine Association (http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333)

determine infrastructure requirements and the appropriate level and types of services needed from the telemedicine/ telehealth start-up and expansion program. Currently, many specialist type consultative services and the opportunities for ensuring clinical preparedness in Kaufman County are limited by fiscal, travel time and distance costs. Also, the technology for the data lines currently deployed for the Lakes Regional core network in Kaufman County have very limited bandwidth (T1 level and below). The data transfer speeds between sites and is slow and very limited for an effective deployment of high definition, internet cloud and server based telemedicine/telehealth technology. Successful implementation of the telemedicine/ telehealth technology will require infrastructure improvements including the latest advancements in technology for telemedicine/ telehealth hardware and server based software. Data network improvements will include high speed data transmission through the deployment of VPN internet cloud capabilities and mobility options. Completion of the necessary analysis and implementation of the required improvements will insure our success with being able to meet the clinical and technological challenges for this project.

5-Year Expected Outcome for Provider and Patients

Through the implementation of this telemedicine/telehealth project, Lakes Regional expects 5-year outcomes to include: 1.) Expanded access to behavioral health services (including psychiatric specialist referral services), and health and wellness services for the target population (low income, rural areas of Kaufman County). The projected outcome for the second half of DY-5 is an 80% improvement over baseline (established in the second half of DY-3) in the number of individuals in the target population gaining access to a specialist/ specialist services. 2.) Continuous quality improvement effort in the technical and clinical processes with documented improvement in the satisfaction of individuals receiving services over base-line/ start-up results.

Starting Point/Baseline:

Lakes Regional has experience with providing services through telemedicine; however we have not implemented or expanded the program into Kaufman County. Providing these telemedicine/ telehealth services in the region will be a start-up program and baseline data for the quality of services and the expansion of the kinds of services provided and the number of individuals served will need to be established. We will begin providing specialist services via telemedicine during the 2nd half of DY-3 and are setting our baseline at a minimum of 30 individuals/e-consultations with a specialist during that period. As soon as our implementation and assessment phase is completed, we will begin data collection to capture ongoing data in many areas of the program. After the first six months of providing specialist services, we will have actual numbers from which quality improvement metrics will be measured against.

Rationale

One of the biggest challenges facing the U.S. healthcare system is to provide quality care to the areas that are currently underserved and lacking access to specialty physicians due to geographic and socioeconomic conditions. With the implementation of a telemedicine/telehealth infrastructure/ program, we are confident that Lakes Regional MHMR Center will be able to close a significant gap in behavioral health (including psychiatric specialist referral services), and health and wellness services being provided for individuals in need that live in rural areas of Kaufman County. The timeframes for implementation and management of the new telemedicine/telehealth program are well within our capabilities. The project milestones and metrics are based on the telemedicine/telehealth program infrastructure deployment, the introduction of new and specialty services and the corresponding growth and continuous improvement in the quality of those services (technically and clinically). With successful implementation of the telemedicine/telehealth program, we plan to reach and exceed the goals we have set for the introduction of new services, service locations, and improvement in the quality of our services and the number of individuals served. The technology will provide the needed flexibility with how and where we provide services. This flexibility will contribute to our growth and after metric baselines are established, we intend to have a significant annual growth rate for the number of telemedicine/telehealth e-consultations/visits for individuals in need while continuously improving the quality of the program. We expect the growth to be significant with an increase of 80% over baseline numbers for the 2nd six months of DY5 for the number of Telemedicine/ Telehealth specialist e-consultations/visits for individuals. Along with our growth, our daily monitoring of the program will enable us to continuously improving the management and quality of the services we provide.

Project components

The selected project components are in line with the 5 year goals we have set and are achievable from our starting point within our planned timeframes. The core project components for Project Option 1.7.1 – "Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region" are as follows:

a. Provide patient consultations by medical and surgical specialists as well as other types of health professionals using telecommunications.
b. Conduct quality improvements using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Our project milestones and metrics are based on the telemedicine program infrastructure deployment and the introduction of new and specialty services along with the planned growth

and continuous improvement in the quality of those services (technically and clinically). Successful implementation of the telemedicine/telehealth project plan will enable Lakes Regional to reach and exceed the goals we have set for the introduction of new services, new service locations, and improvement in the quality of our services and the number of individuals served (210 at the completion of DY5).

Specify the unique community need identification number the project addresses

- CN.5: Behavioral Health
- CN.7: Behavioral Health and Jail Population
- CN.12: Emergency Department Usage and Readmissions

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

Lakes Regional is currently providing services through telemedicine at some of our larger clinics, but we have not implemented or expanded the program into Kaufman County. Providing these telemedicine/ telehealth services is a new initiative for us in this region and will be a start-up program. This plan will enable us to significantly enhance our existing services delivery system. Our telemedicine/ telehealth infrastructure system/ program will enable flexible delivery of care and improved delivery times for services. Doctors will be able to connect to individuals in the rural clinics and provide services without needing to be located there (they can be at another clinic or even at their home office). Mobility through I-cloud connectivity will enable Lakes Regional to have the flexibility to provide connectivity to areas where access to services has been difficult for individuals' in need. Lakes Regional will be able to setup multiple connections to include private physicians, hospitals, other MHMR Centers, and other providers or resources in the community wherever they may be located.

Related Category 3 Outcome Measures:

IT-6.1 Percent improvement over baseline of patient satisfaction scores measuring patient's overall health status/functional status.

Although this Telemedicine/Telehealth Introduction/Expansion Project will enable services from multiple provider specialties in Kaufman County, it will share significant focus with the Lakes Regional Crisis Respite – Behavioral Support Wraparound Program Project. Within the IDD population, research has shown that there is a much greater instance of health problems[119]. With the help of telemedicine/telehealth technology, program staff will monitor mental and physical health status and outcomes to facilitate integrated care, improvement of patient satisfaction and outcomes for the target population[120]. The specific ACT model planned for the program will result in better control of psychiatric symptoms, better quality of life overall, and

[119] Journal of Intellectual Disability Research 48 (2): 93-102, 2004
[120] Journal of Applied Research in Intellectual Disabilities. 19: 214-218

greater consumer and family member satisfaction [121]. The projected outcomes relate to an improvement in access to care, the quality of care and health outcomes, as well as an overall improvement in health for the target population. The CG-CAHPS survey produces ". . . comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers[122]. The sharing of consumer satisfaction data (overall health survey results) between agencies and providers in the region regarding consumer satisfaction, will result in a greater awareness of the efficacy of the crisis respite wraparound model in improving life satisfaction, following better self-management skills and follow-up to care. Identified within the Crisis Respite Project there is significant data analysis planned with encounter based assessments to show and measure improvement in customer satisfaction in health/ functional status.

Relationship to other Projects

This project is related to 121988304.1.1 - Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system, "Crisis Respite – Behavioral Support Wraparound Program." Telemedicine technology will be utilized as an integral focus of the provision of care proposed in this project.

Related Category 4 Population-focused improvements: N/A

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

We plan to play an active role in the development and ongoing conduct of a Project Learning Collaborative, appropriate to our project, as organized by RHP 9 and described in Section IV-Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Our telemedicine/telehealth project will provide great flexibility for the type of services and where the connections between providers can be established. With the rural nature of Kaufman County, the internet cloud based implementation planned for the project will open up the area for video communication between doctors' offices, schools, hospitals, jails, behavioral health clinics, and just about anywhere that there is broadband access (providers working out of their homes). The possibilities for expansion of this program are numerous and the services provided will result in overall cost reductions for the region. The project intervention was

[121] Phillips et al, 2001. . .Teague et al, 1995
[122] RHP Planning Protocol, page 398

valued based on studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: "Valuing Access to Timely Services through Telemedicine." These studies were completed through a contract with Center for Health Care Services. These valuation studies used cost-utility analysis which measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a monetary value of QALY gained due to the intervention multiplied by number of participants. The reviewed research cited Hollinghurst et al. (2010), among others which yielded a QALY gain per 100 patients served for a similar project population. Utilizing this research yielded the total valuation of **$1,791,134**.

Complete write-up of project research is available at the performing provider site. Additional cost effectiveness savings can also be assumed through avoidance of higher cost crisis emergency based services and transportation costs as a result due to the increased access due to this project.

121988304.1.2	***1.7.1***	***1.7.1 A-B***	*IMPLEMENT TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES IN AN AREA IDENTIFIED A NEEDED TO THE REGION.-- (LAKES REGIONAL – KAUFMAN COUNTY TELEMEDICINE/TELE-HEALTH PROJECT)*	
Lakes Regional MHMR Center				*121988304*
Related Category 3 Outcome Measure(s):	*121988304.3.2*	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status.*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct needs assessment 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. Baseline/Goal: Personnel needs assessed. Data Source: Needs Assessment Milestone 1 Estimated Incentive Payment: *$207,883* **Milestone 2** [P-7]: Create plan to monitor and enhance technical properties, bandwidth, or telemedicine/ telehealth program. Metric 1 [P-7.1]: Documentation of bandwidth capacity in relationship to program needs. Baseline/Goal: Capacity plan completed. Data Source: Bandwidth assessment and program plan. Milestone 2 Estimated Incentive Payment: *$207,883*	**Milestone 3** [P-3]: Implement or expand telemedicine program for selected medical specialties, based upon regional and community need. Metric 1 [P-3.1]: Documentation of program materials including implementation plan, vendor agreements/ contracts, staff training and HR documents. Baseline/Goal: Telemedicine program implemented. Data Source: Program records. Metric 2 [P-3.2]: Documentation of the number of consults delivered by each specialty. Baseline/Goal: Number of consults delivered by each specialty documented. Data Source: Clinic log of health services provided via telemedicine. Milestone 3 Estimated Incentive Payment: *$288,958* **Milestone 4** [I-17] Improved access to specialists care or other needed	**Milestone 5** [I-17 Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.1]: Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using the services for the first time. Numerator: Number of patients participating in program that are using each service for the first time during the reporting period. Denominator: Number of patients that are participating in the program or are in the target population. Goal: 20% improvement over baseline. Serve an additional 36 individuals in 1st 6 month period of DY-4. Data Source: Encounter records from telemedicine program Milestone 5 Estimated Incentive Payment: *$206.612*	**Milestone 7** [I-17]: Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.1]: Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using for the first time. Numerator: Number of patients participating in program that are using each service for the first time during the reporting period. Denominator: Number of patients that are participating in the program or are in the target population. Goal: 60% improvement over baseline. Service an additional 48 individuals in 1st 6 month period of DY-5. Data Source: Encounter records from telemedicine program Milestone 7 Estimated Incentive Payment: *$192,113*

121988304.1.2	***1.7.1***	***1.7.1 A-B***	*IMPLEMENT TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES IN AN AREA IDENTIFIED A NEEDED TO THE REGION.-- (LAKES REGIONAL – KAUFMAN COUNTY TELEMEDICINE/TELE-HEALTH PROJECT)*		
Lakes Regional MHMR Center					*121988304*
Related Category 3 Outcome Measure(s):	*121988304.3.2*	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status.*		
Year 2 (10/1/2012 – 9/30/2013)			**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17-1]: Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using the services for the first time. Numerator: Number of patients participating in program that are using each service for the first time during the reporting period. Denominator: Number of patients that are participating in the program or are in the target population. Baseline = 30 Goal: Baseline set - minimum of 30 individuals/ e-consultations with a specialist. Data Source: Encounter records from telemedicine program. Milestone 4 Estimated Incentive Payment: *$288,959*	**Milestone 6** [I-17] Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.1]: Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using the services for the first time. Numerator: Number of patients participating in program that are using each service for the first time during the reporting period. Denominator: Number of patients that are participating in the program or are in the target population. Goal: 40% improvement over baseline. Serve an additional 42 individuals in 2nd 6 months of DY-4. Data Source: Encounter records from telemedicine program. Milestone 6 Estimated Incentive Payment: *$206,613*	**Milestone 8** [I-17] Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.1]: Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using the services for the first time. Numerator: Number of patients participating in program that are using the each service for the first time. Denominator: Number of patients that are participating in the program or are in the target population. Goal: 80% improvement over baseline. Serve an additional 54 individuals in 2nd 6 months of DY-5. Data Source: Encounter records from telemedicine program. Milestone 8 Estimated Incentive Payment: *$192,113*

121988304.1.2	***1.7.1***	***1.7.1 A-B***	*IMPLEMENT TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES IN AN AREA IDENTIFIED A NEEDED TO THE REGION.-- (LAKES REGIONAL – KAUFMAN COUNTY TELEMEDICINE/TELE-HEALTH PROJECT)*
Lakes Regional MHMR Center			*121988304*
Related Category 3 Outcome Measure(s):	*121988304.3.2*	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status.*

Year 2 (10/1/2012 – 9/30/2013)	**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):* **$415,766**	Year 3 Estimated Milestone Bundle Amount: **$577,917**	Year 4 Estimated Milestone Bundle Amount: **$413,225**	Year 5 Estimated Milestone Bundle Amount: **$384,226**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** **$1,791,134**			

Project Option 1.7.1 - Expand Telemedicine and Telehealth for Stoke Treatment

Unique Project ID: 020943901.1.1
Performing Provider Name/TPI: Medical City Dallas/020943901

Provider: Medical City Dallas is a 586 -bed acute care hospital in Dallas Texas serving a Primary and Secondary Service Area population of approximately 3.2 million.

Intervention(s): This project will expand telemedicine to provide neuro-inteventionalist/specialist access for specialty care for stroke patients. Hospital emergency room physicians will have access to consulation via telemedicine phone consults and have the technological capability for people to connect via bi-directional video cameras for consultations.

Need for the project: Currently many hospitals in the region do not have access to a neur-specialist on their medical staff to assess and treat patients presenting with stroke symptoms. Patients are not properly treated without neuro-specialty care access which results in severe disability and even death that creates additional costs and burdens to healthcare system and society. Mortality for uninsured patients who suffer a stroke is 49% higher than insured patients and average length of stay is also significantly higher.

Target population: The target populationare patients who present to emergency rooms with stroke symptoms. These patients need to be assessed and treated with in one hour for optimal care. Approximately 20% of the patients in the region with stroke are Medicaid or indigent.

Category 1 or 2 expected patient benefits:. It is estimated we will use telemedine to diagnose, triage and treat stroke patients of DY2-2,000, DY3-3,000,DY4-4,000, DY5-5,000. Patients will received neuro-specialist consults to triage, diagnose and decide treatment plan for patients who would otherwise not have access to a neuro-specialist.

Category 3 outcomes:

- IT-4.10 IV tPA Treatment Rat for Stroke Patients. Our goal is to increase treatment rate to 15% by DY 5.
- IT-4.10 Decrease ALOS Our goal is to reduce the length of stay by 5% in DY 4 and 5% in DY 5 for a total reduction of 10%.
- IT-4.10 Door to Needle time IV-t-PA administration. Our goal is to improve time by 10%DY 4 and 10%in DY5 for a total reduction of time by 20% from baseline

Project Description

Medical City Dallas has developed an effective and resource-efficient plan to reduce the morbidity, mortality and economic burden of stroke across the north Texas region. The foundation of this plan is the alignment of regional hospitals who voluntarily join together to form a system of stroke care.[1] Participants use standard, best evidence-based protocols in order to achieve consistent, high-quality care across the continuum. In turn, facilities gain immediate access to a vascular neurologist via telephone and/or remote presence for their patients who suffer acute stroke. Remote presence is the technological capability for people to connect via bi-directional video cameras placed at differing geographical end points (telestroke).

Telestroke technology is vital to the success and maturation of a stroke system of care.[1] It provides patients in both rural and urban hospitals with real-time, bedside access to neurovascular physicians for the rapid triage and management of stroke. These specialists help emergency room physicians in the decision making process to use intravenous (IV) thrombolysis with tissue plasominogen activator (tPA). They also assess patients' eligibility for catheter-based treatments for ischemic stroke (intra-arterial thrombolysis and clot-retrieval devices) and hemorrhagic stroke (brain aneurysm coiling and brain AVM embolizations). The ability to examine and communicate with patients, view imaging studies, and interview the families also assists physicians in deciding whether the patients need to be transferred to a higher level of care, or if unnecessary transfers can be avoided.

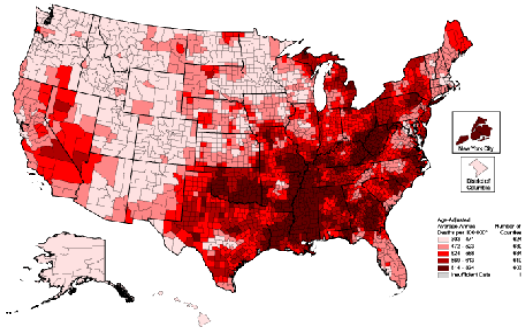
Medical City Dallas launched this initiative in March, 2010 and the network has continued to grow. While over 60 hospitals have contacted physicians by telephone, only eleven facilities in the network currently have remote presence capability. Many more hospitals in our region are seeking telestroke support to help save patient's lives and decrease disability due to stroke.

Goals and Relationship to Regional Goals

The 5 year goals of this initiative are to 1) to improve outcomes for patients who suffer stroke by providing access to specialists who deliver both the standard of care and cutting-edge therapies, and 2) decrease healthcare costs associated with acute stroke by triaging patients to the appropriate facility and avoiding unnecessary transfers.

Telestroke networks have been developed around the globe in both rural and urban settings. Telemedicine has facilitated a 4-fold increase in the rate of administration of tPA within a 3-4.5 hour window.. Telemedicine has also demonstrated use in remote treatment and subsequent transfer of patients with acute stroke using the "drip and ship" paradigm.[3]

Despite advances, no such network has been developed in north Texas, until now. Stroke care is an ideal application of remote presence technology because of its large societal impact on both cost and quality of life for patients. Current treatment rates are difficult to assess, but are known to be low.[4] With improved access, treatment rates can rise higher than 21%.[5] Medical City Dallas will target north Texas hospitals whose treatment rates remain below 10%.



North Texas is part of the "Stroke Belt"

In Age-Adjusted Death Rates per 100,000 Population for Stroke by State: Texas Ranks #41
http://circ.ahajournals.org

This project supports the regional goals to improve the patient care experience, health outcomes for the population and the per capita cost of care.

Challenges

Stroke is an unscheduled event that can happen to anyone at any location. Treatment of stroke is time-sensitive and thus requires physician specialists who are in short supply to diagnose and may also require subspecialists and technologies that are geographically few and far between but necessary for life-saving treatments.[2]

Medical City Dallas has secured vascular neurology expertise to handle large call volumes. Physicians are on call 24/7/365 for any area emergency medicine physician or other physicians through a primary one-call transfer center line at no charge. Additional vascular neurologists (3) were recruited in 2012 to accommodate increasing calls (average call volume = 15/day) and to be able to expand and grow the network.

The added implementation of telestroke is an ideal application that can lead the way to a new and improved paradigm of healthcare delivery. Recognizing the need in north Texas to expand the quality of stroke services, Medical City Dallas has partnered with In Touch Telehealth® to provide technology equipment and with QuestCare Telehealth, Inc for additional physician manpower for those facilities that lack full time neurology coverage in their emergency departments.

5-Year Expected Outcome for Provider and Patients

Years 2-5 (2013-2016): During this four year period, Medical City Dallas will deploy and support 40 additional remote presence cameras in north Texas to access neuro-specilaty care. Quality Metrics will be continuously monitored and achieved, bi-directional data will be shared between sending and receiving hospitals, patient case studies and education will be provided by physicians and staff. Patient discharge destination data will be collected, reviewed and publicly reported. At the end of 5 years with 40 additonal sites, we will have increased treatment rates (IV t-PA) for stoke patients by15% for the targeted population and created a telestroke program for these sites to support efficient stroke care for treatment within 60 minute goal.

Starting Point/Baseline

Starting point of this project expansion in Year 1 (2012) deployed eleven operational cameras within the system (internal). Two additional external cameras will become operational by the end of 2012 – Wise Regional (Decatur) and Hendrick (Abilene).Quality metrics have been established and will be monitored for any adjustments needed through 2012.

Rationale

Currently there are several treatment options for patient with active stroke symptoms however time is critical in diagnosing anf treating for optimal outcomes.

An ischemic stroke patients' window of opportunity for treatment is 12 hours for an optimal health outcome. The best outcome is for patients to be treated with tPA with in first 3 - 4.5 hours of first symptoms to dissolve the blood clot and restore blood flow to the brain. For patients who are not diagnosed within the 4.5 hours of first symptoms, an assessment to see if a patient will qualify for comprehensive treatment will be performed up to 12 hours after first symptoms. Patients who qualify can receive catheter-based treatments such as intra-arterial thrombolysis and clot-retrieval devices. Patient with hemorrhagic stroke may receive brain aneurysm coiling and brain AVM embolizations. However none of these treatments will be possible without access to a neuro-specilist.

The use of IV tPA in community hospitals has been limited by the lack of neurologic support. The main barrier to increasing treatment among those patients arriving within 3-4.5 hours is physician reluctance to deliver therapy in absence of available acute stroke expertise around the clock.

Systems of care that provide neurologic support via telemedicine have been able to increase treatment rates by as much as 72%.[2]
In addition to raising treatment rates for acute ischemic stroke, it is important to avoid unnecessary transfers. Often patients are transferred from rural areas when no additional treatment options are available upon their arrival.
This is a both a burden to the patients and their families, as well as an economic burden to the healthcare system. With access to telestroke specialists, facilities can access better triage and diagnosis to better determine treatment options for patients. Medical City Dallas will collect, analyze and report the impact of instituting telestroke to ensure that target metrics are met. Results will be posted and will be made available to EMS agencies and hospitals across the region.

Project Option:
Currently, there are 60 metroplex hospitals and 52 rural hospitals that access curbside consult care through the Medical City Dallas's North Texas transfer center. Calls regarding stroke triage and care emanate from any one of these facilities for emergent care. Since March 2010, over 64

facilities have called the Medical City Dallas contracted physicians for assistance. The goal of this project is to have an additional 40 sites with telemedicine cameras at the end of the waiver that can perform assessment and treatment via consults.

Medical City Dallas launched this initiative in March, 2010 and the network has continued to grow. While over 60 hospitals have contacted physicians by telephone, only eleven facilities in the network currently have remote presence capability. Many more hospitals in our region are seeking telestroke support to help save patient's lives and decrease disability due to stroke.
There are three vascular neurologists that are on primary stroke call and four interventional neurologists that take comprehensive call (those patients that need endovascular treatment). All seven neurologists are trained in both vascular and neuro-critical care medicine. Average number of calls per day = 15.

The telestroke network will establish milestone and metrics to measure number of consults and establish appropriate protocols and training for staff and physicians will be put in place for how and when to use telemedicine consults. Training will be necessary on telemedicine equipment as well.

It is important that physicians have timely access to neurology consults, we will put in place a measure to ensure once consult is initiated that it is delivered in appropriate time frame (15-20 minutes).

Additional care coordination and conferences will be necessary as part of education, training and outreach.

Project Components

The core components of Project 1.7.1 will be implemented:

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

b) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Unique Community Need Identification Numbers the Project Addresses

The community needs assessment identification number CN.9 Specialty Care supports this project.

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

Developing alternative networks for the delivery of health care has been a stated goal in the debate on healthcare reform. There is the acknowledged need to innovate toward new healthcare models that reduce cost and yet improve quality and accessibility.[3]

Related Category 3 Outcome Measure(s):

IT-4.10 Safely increase the treatment rates of ischemic stroke with IV t-PA from the current estimated 3% - 4% to greater than 10% for the entire system within 4 years. Specific metrics measured: rate of IV tPA treatment (%) for all acute ischemic stroke patients presenting to facility that are eligible (exclusion criteria applied):

- Numerator= # of patients who received IV tPA treatment

- Denominator= Total # of ischemic stroke patients eligible for treatment

The NINDS trial showed that patients who received IV t-PA therapy have better outcomes.[7] Discharge destinations will be monitored and Modified Rankin scores at 90 days performed to determine level of disability post stroke.

IT-4.10 Other: Door-to-needle time for the administration of IV tPA < 60 Minutes. IV tPA is the only FDA approved treatment for ischemic stroke patients in the first 4.5 hours from first onset of symptoms to restore blood flow in the brain. Because of the importance of rapid treatment, national guidelines recommend that hospitals complete the clinical and imaging evaluation of acute ischemic stroke patients and initiate intravenous tPA therapy within 60 minutes of patient arrival in those without contraindications. Providing IV tPA with short door-to-needle time reflects acomplex clinical process requiring coordination across departments and disciplines to effect timely triage, diagnosis, decision making, and treatment of a critically ill acute ischemic stroke patient. The telestroke program goal is to provide specialty care access to faciliate triage , diagnosis and decision making. The speed with which the patient receives IV t-PA is inversely proportional to the patients outcome, thus decreasing door-to-needle times for the administration of IV tPA to less than 60 minutes in at least 50% of all patients who receive IV tPA via telestroke within 2 years will be a project goal.[8] Specific metrics measured: time of call to neurology expertise and time of consult to delivery of medication.

IT -4.10 Other: Decrease length of stay (LOS) by increasing treatment rates and decreasing unnecessary transfers. All telemedicine stroke consults will be tracked to ensure that LOS is positively impacted. Goal: to decrease LOS by 10% of the overall ischemic stroke patients.

The Telestoke program will also measure the Symptomatic intracerebral hemorrhage (sICH) rate. It will be assessed post IV t-PA using the following criteria: Any evidence of hemorrhage on imaging combined with NIHSS worsening > 4 points.[6] This will ensure that IV t-PA is given safely – all complications from sICH will be reviewed with hospital to verify that protocol adherence was not violated

Increase access to both the standard of care and cutting –edge therapies in acute stroke, while decreasing unnecessary transfers and costs to patients and the cerebrovascular healthcare delivery system. Specific metrics to measure: time of decision to transfer to arrival.

Relationship to other projects

This project supports reducing Category 4 population focused improvements 020943901.4.5 RD-4 Patient-centered Healthcare in improving the patient experience with timely and appropriate access to specialty care.

Relationship to other Performing Providers in the RHP and Plan for earning Collaboratives

Other proposed projects to address integrated primary and behavioral health services include:

- HCA Medical City 020943901.1.2
- Lakes Regional 121988304.1.2
- UTSouthwestern 126686802.1.4

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology Medical City Dallas defined the population that will be directly impacted by the project as patients receiving a neuro-specialist consult. To provide these consults, neuro-specialists will need to be secured and available 24/7 for 40 additional sites. The estimate value is $1,092,000 for 4 years of the project based on minimum 30 minute time per consult valued at $78 each -annual income of specialist 650k year and volumes ,DY2-2000,DY3-3000, DY4-4000, DY5-5000. It will be necessary to continue to train physicians and

staff on stroke protocols, treatment and use of technology. This is estimated at $183,00 per year for 4 years for a total value of $732,000.
It is also projected a 15% Treatment Rate for IV tPA in targeted population will result in less disability or severe disability in patients. We estimate 25% of the patients will be eligible for IV tPA (3500 patients, DY2-500, DY3 -750, DY4-1000, DY5-1250) and treatment rate at 15% by DY 5, total 365 patient would receive treatment who would not have otherwise(DY2-25, DY3-52, DY4-100, DY5-188). Of these 120 patients, 33% would have not long term disability bases on trial studies (DY2-8, DY3-17,DY4-33,DY5-62). It is estimated based on a British study, annual direct cost of disabled stroke patients and lost productivity was $30,600, for a total of $3,672,000.
In addition, length of stay will be reduced for stroke patients. We estimate this to be approximately 945 days with internal cost estimates per day of $1,000. This is a total value of $945,000.
The remainder of $23,085 for total value was reduced to balance total funding.

The total value of the project then was estimated at $6,417,915. Approximately 80.62% of the total value was assigned to Category 2 project ($5,174,491) and the remaining value was assigned to Category 3 outcomes 6.46% IV TPA Treatment Rate ($414,470), 6.46% for Average Length of Stay ($414,471) and 6.46% for Door To Needle Time ($414,483.

Rationale/Justification: Outcome improvement targets are dependent on the target population served, size (e.g. if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that to treat stroke patients.

End Notes/References

[1] Schwamm et al. Recommendations for the Implementation of Telemedicine Within Stroke Systems of Care: A Policy Statement from the American Heart Association. *Stroke* 2009; 40: 2635-2660
[2] Frey,et al. tPA by telephone: Extending the benefits of a comprehensive stroke center. Neurology 2005, 64: 154-156
[3] Wang, et al. Enabling Technologies Facilitate New Healthcare Delivery Models for Acute Stroke. *Stroke* 2010;41;1076-1078 DOI: 10.1161/STROKEAHA.110.587261
[4] Mullen, et al. (2012). TPA delivery in PSCs = 3.12%
[5] Rymer, Marilyn. Increasing Ischemic Stroke Treatment Rates: What is a Realistic Goal? *Endovascular Today*, 2010
[6] Singer et al. Risk Assessment of Symptomatic Intracerebral Hemorrhage After Thrombolysis Using DWI-ASPECTS. Stroke. 2009; 40:2743-2748
http://stroke.ahajournals.org/content/40/8/2743
[7] Tissue Plasminogen Activator for Acute Ischemic Stroke, *The New England Journal of Medicine* 1995. Volume 33 No 24
[8] Fonarow, et al. Timeliness of Tissue-Type Plasminogen Activator Therapy in Acute Ischemic Stroke: Patient Characteristics, Hospital Factors, and Outcomes Associated With Door to Needle Time 60 Minutes, *Circulation*. 2011;123:750-758.)
http://circ.ahajournals.org/content/early/2011/02/10/CIRCULATIONAHA.110.974675

020943901.1.1	*1.7.1*	*1.7.1A-B*	*EXPAND TELEMEDICINE AND TELEHEALTH FOR STOKE TREATMENT*	
Medical City Dallas				*020943901*
Related Category 3 Outcome Measure(s):	*020943901.3.1* *020943901.3.2* *020943901.3.3*	*3 IT -4.10* *3 IT-4.10* *3 IT-4.10*	*IV tPA Treatment Rate Stroke Patients* *Decrease ALOS* *Door to Needle time IV-t-PA administration*	
Year 2 (10/1/2012 – 9/30/2013)		**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 or expand telemedicine program for selected medical specialties, based upon regional and community need. Metric 1 [P-3.1.]: Documentation of program materials including implementation plan vendor agreements/ contracts, staff training and HR documents. Baseline/Goal: Document Data Source: Program materials Metric 2 [P-3.2.]: Documentation of the number of consults delivered by each specialty Goals: 2,000 Data Source: Program materials Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,265,497		**Milestone 2** [P-3]: Implement or expand telemedicine program for selected medical specialties, based upon regional and community need Metric 1 [P-3.2.]: Documentation of the number of consults delivered by each specialty Goal: 20% improvement over baseline Data Source: Telemedicine and transfer center reports Milestone 2 Estimated Incentive Payment *(maximum amount):* $690,294 **Milestone 3** [P-X]:Conduct continuous quality improvement activities for Telemedicine program Metric 1 [P-X]: Submission of Process Improvement Project Plan Goal: complete all steps for QA activities Data Source: Telemedicine Process Improvement Project Plan	**Milestone 4** [I-X]: Increase number of telemedicine consults for each specialty identified as regional need. Metric 1 [I-X]: Number of Telemedicine consults Goal: 4,000 consults Data Source: : Telemedicine and transfer center reports Milestone 4 Estimated Incentive Payment: $461,534 **Milestone 5** [I-X]:Reduce time to neurology consult Metric 1 [I-X]: time of call to initiate consult to neurology expertise/consult delivered Goal: 10% improvement over baseline Data Source: Telemedicine and transfer center reports Milestone 5 Estimated Incentive Payment: $461,534 **Milestone 6** [I-17]: Improved access to	**Milestone 7** [I-X]: Increase number of telemedicine consults for each specialty identified as regional need. Metric 1 [I-X]: Number of Telemedicine consults Goal: 5,000 consults Data Source: : Telemedicine and transfer center reports Milestone 7 Estimated Incentive Payment: $381,267 **Milestone 8** [I-X]:Reduce time to neurology consult Metric 1 [I-X]: time of call to initiate consult to neurology expertise/consult delivered Goal: 20% improvement over baseline Data Source: Telemedicine and transfer center reports Milestone 8 Estimated Incentive Payment: $381,267 **Milestone 9** [I-17]: Improved access to

020943901.1.1	*1.7.1*	*1.7.1A-B*	*EXPAND TELEMEDICINE AND TELEHEALTH FOR STOKE TREATMENT*	
		Medical City Dallas		*020943901*
Related Category 3 Outcome Measure(s):	*020943901.3.1* *020943901.3.2* *020943901.3.3*	*3 IT -4.10* *3 IT-4.10* *3 IT-4.10*	*IV tPA Treatment Rate Stroke Patients* *Decrease ALOS* *Door to Needle time IV-t-PA administration*	
Year 2 (10/1/2012 – 9/30/2013)		**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: $690,295	specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. <u>Metric 1</u> [I-17.3]: Improved access to care coordination in a way that would otherwise not have occurred. Goal: 30 sites access telestroke specialty consults Data Source: : Telestroke Outreach Plan Milestone 6 Estimated Incentive Payment: $461,535	specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. <u>Metric 1</u> [I-17.3]: Improved access to care coordination in a way that would otherwise not have occurred. Goal: 40 sites accessing telestroke specialty consults Data Source: Telestroke Outreach Plan Milestone 9 Estimated Incentive Payment: $381,268
Year 2 Estimated Milestone Bundle Amount: $1,265,497		Year 3 Estimated Milestone Bundle Amount: $1,380,589	Year 4 Estimated Milestone Bundle Amount: $1,384,603	Year 5 Estimated Milestone Bundle Amount: $1,143,802
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $5,174,491				

Project Option 1.7.1 - Implement telemedicine program to provide or expand specialist referral services in an area identified as needed in the region. (Implement a Telepsychiatry program to improve Specialty Care Access for Behavioral Health)

Unique Project ID: 020943901.1.2
Performing Provider Name/TPI: Medical City Dallas/020943901

Provider: Medical City Dallas is a 586 -bed acute care hospital in Dallas, Texas serving a Primary and Secondary Service area population of approximately 3.2million.

Intervention(s): This project will expand telemedicine to provide consultations by a psychiatrist to emergency room or internal medicine physicians for patients with psychiatric diagnosis to facilitate appropriate and timely treatment for behavioral health /substance abuse diagnoses.

Need for the project: Currently psychiatrists are not available to treat patients in Emergency rooms and are limited for inpatient treatment of patients with psychiatric conditions present at an acute care hospital. ED and internal medicine physicians are limited in their ability and comfort in treating psychiatric disorders. It takes 24 hours to 3 days for hospitals in the region to get patients appropriate treatment including but not limited to placement.

Target population: The target population is patients that need psychiatric assessment and treatment who present to acute care emergency rooms. Approximately 70% of patients at the hospitals served by this project that present to an ED a with a behavioral health primary diagnosis are Medicaid eligible or indigent. We expect at least 60 % of the consults for behavioral health will be delivered via telemedicine by DY 5.

Category 1 or 2 expected patient benefits: The project seeks to provide psychiatric medicine consults to patients in ED. It is expected there will be consults of DY3-2,991, DY4-3,595 and DY 5-3,703. It is expected that a percentage of these consults will be consult via telemedicine cameras verus phone or in person consults from a mid-level practioner. We expected these ot be DY3- 1500, DY 4-2,300 andDY5-2,400.

Category 3 outcomes: IT-2.4 Our goal is to reduce the Behavioral Health/Substance Abuse Admissions by 152 admission. We estimate the rate as defined by protocol to be .505% in the region. This would reduce the rate by1%by DY5.

Project Description

This project will implement a telemedicine program with psychiatric specialists to be able to consult, evaluate and treat patients at remote sites. For this program Medical City Dallas will contract with Green Oaks Hospital in Dallas will provide access to psychiatric providers to hospitals in the region and across the state to obtain the services necessary from these specialists. These specialists may be located in the region but due to travel and distance limitations they cannot see patients in multiple locations in an efficient manner. The

telemedicine program would allow access to those specialists for consultations and treatments. Medical staff credentialing and program policies and procedures will be developed as well as equipment procurement in order to implement the program.
A team of behavioral health specialists will be available to be onsite as well to do an assessment to determine if a telemedicine psychiatric consult is appropriate. If appropriate, a consult with a psychiatrist will take place. The outcome of the psychiatric consults will vary but they can determine appropriate medications, treatment courses, clearance for discharge and appropriate level of care for discharge.

DY 2 would serve as a baseline period to measure the number of patients in the target population. Although we have information on patients from the hospital with behavioral health diagnosis, these would not be the total target population as coding variations and a range of behavioral diagnosis do not accurate report patients that this program would serve. We are currently estimating volumes based on coded claims and estimates of patient that will need psychiatric care versus mid-level practitioner care will need further baselining in DY2.

Goals and Relationship to Regional Goals

The goal of the project is to have psychiatric consults available for evaluation and treatment of patients so we can decrease the time to obtain a consult, obtain appropriate and timely treatment as necessary and discharge and place patients in the appropriate level of care. Acute care hospitals have limited or no available medical staff with this specialty. Also, there is an acute shortage in the metro area for psychiatric providers thus the entire region is underserved. By implementing the telemedicine option, hospitals will be able to access consults by psychiatrist for patients in emergency rooms and hospitals. Currently due to the lack of specialty care access, emergency room physicians and internal medicine physicians due their best to stabilize patient while waiting for psychiatric beds or treatment. Telemedicine supports efforts to enhance, expand and improve the efficiency and timeliness of specialty care services in the community

This project supports the regional goals to improve the patient care experience, health outcomes for the population and the per capita cost of care.

Challenges

Like many communities in the country, the Dallas-Fort Worth is experiencing a growing patient demand for behavioral health care services. In addition, the prevalence of co-occurring behavioral health conditions with medical encounters has increased the complexity of care and need for coordination with mental health professions in the acute care setting. The current mental health workforce shortage limits the availability of psychiatrist to be on medical staffs at acute care hospital providers. Because there are no available medical staff with this specialty, access to care can be delayed. It can take anywhere from 24 hours to 3 days for hospitals in the region to get patients appropriate treatment including but not limited to placement in psychiatric hospital. In some instances, in order to obtain necessary evaluation for acute

patients, they may be transferred to multiple hospitals for a single episode of care, resulting in increased cost and service duplication, with more opportunities for errors and coordination problems. In implementing a telemedicine program it will be important that the technology is user friendly, regular training session take place, and physicians are comfortable with knowing when to use the service.

The purpose of performing this project is to facilitate the access to psychiatric specialists for consults and treatment.

5-Year Expected Outcome for Provider and Patients:

This project will address the need for timely specialist consults for patients by access specialist via telemedicine options. Apercentage of these consults will be via telemedicine cameras verus phone or in person consults from a mid-level practioner It is expected at the end of waiver we will have at least 60% of behavioral health consults will be delivered via telemedicine.

Starting Point/Baseline:

DY 2 would serve as a baseline period to measure the number of patients in the target population. Although we have information on patients from the hospitals with behavioral health diagnosis, these would not be the total target population as coding variations and a range of behavioral diagnosis do not accurate report patients that this program would serve.

Rationale

The use of technology to deliver health care from a distance, or telemedicine, has been demonstrated as an effective way of overcoming certain barriers to care. In addition, telemedicine can ease the gaps in providing crucial care for those who are underserved, principally because of a shortage of sub-specialty providers. The hospital experiences a growing number of patients presenting with mental and behavioral health illness that cannot be appropriately assessed and treated by Emergency room physicians and hospitalists.
As noted in the 2009 California HealthCare Foundation report, Telepsychiatry in the Emergency Department: Overview and Case Studies "mental health-related patients in the ED disproportionately affects the operation of the ED for other patients in terms in space, staffing and resources. Safety issues arise for these patients, other patients and staff. To further complicate matters, many EDs are not properly equipped to handle most mental health emergency patients, which has led to improper diagnoses, prolonged ED stays, and misuse of physical restraints.[18,19]"
Giving these physicians and staff access to appropriate specialist in the hospital setting will allow for timely, appropriate assessment, treatment and proper discharge planning. An additional benefit is the increased psychiatric knowledge of the ED physicians and staff after implementing the program from their continued contact with psychiatrists. With improved access to specialists, we expected increased quality and patient satisfaction with care, improved clinical outcomes, improved emergency room throughput and cost savings.

Project Components

The core components of Project 1.7.1 will be implemented:

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

b) 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.

It will be necessary to have a baseline number of patients who are in need of a psychiatric consult. Today we only have limited information on consults ordered by medical records. Medical City Dallas currently contracts with Green Oaks Hospital to provide assessments at the hospital sites via behavioral health specialists or transports patients to the hospital to be assessed. In 2011 they assessed over 150 patients at Medical City Dallas and 7,000 in the region. However, the behavioral health specialists used at remote sites are not psychiatrists and limited in their ability of services to provide. A needs assessment will be conducted identify volume /baseline of patients that need a psychiatric consult that can be delivered via telemedicine. Specific protocols will be put in place for how and when to use telemedicine consults. Once the need is quantified, telemedicine program can begin a project plan to implement the program. The implementation will involve policy and procedure development, medical staff credentialing, procurement of equipment, and training of staff and physicians. Continuous quality improvement activities will be utilized ensure successful implementation. Metrics to measure volume of consults and timeliness of patient disposition on consult is obtained will assist in measuring the effectiveness of the program.

Unique Community Need Identification Numbers the Project Addresses

This project addresses the shortage of Specialty Care in the region as well as access to Behavioral Health services. These are identified in the community needs assessment as CN.9 Specialty Care and CN.5 Behavioral Health.

How the Project represents a new initiative

The project is a new initiative for Medical City Dallas and Green Oaks Hospital as they are currently piloting the telemedicine program for behavioral health care 2012. Green Oaks Hospital is an inpatient psychiatric acute provider in Dallas, Texas and part of the NorthSTAR provider network. The NorthSTAR Behavioral Health program has been jointly administered by

the Texas Department of Mental Health and Mental Retardation (TDMHMR) and the Texas Commission on Alcohol and Drug Abuse (TCADA) as a 1915(b) Medicaid Waiver program in a seven-county area around Dallas. The program serves the medically indigent and most Medicaid recipients who reside within this region. Green Oaks Hospital also performs the screening of patients before admission to inpatient treatment for ValueOptions. ValueOptions NorthSTAR is the BHO (Behavioral Health Organization) who is responsible for the maintenance of the provider network and care management for the enrollees. This telemedicine program would be a new initiative to serve NorthSTAR and non- NorthSTAR patients and hospitals in the region.

Related Category 3 Outcome Measure(s)

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

Due to lack of access to specialists, patients are often admitted until consult can be obtained. By giving physician and staff access to specialist, they can determine appropriate treatment and level of care necessary to reduce admission rate. Patients admitted require more intense service such one on one care leaving other resource stretched and other care exposed position to care for other patients.

Relationship to other projects

This project supports reducing Category 4 population focused improvements 020943901.4.2 RD-1 Preventable admissions and 020943901.4.3 RD-2 30- day readmissions by allowing specialist to assess and patients timely and in the appropriate setting. This project also supports 020943901.4.5 RD-4 Patient-centered Healthcare in improving the patient experience with timely and appropriate access to specialty care.

Relationship to other Performing Providers in the RHP and Plan for earning Collaboratives

Other proposed projects to address integrated primary and behavioral health services include:

- HCA Medical City 020943901.1.2
- Lakes Regional 121988304.1.2
- UTSouthwestern 126686802.1.4

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared

learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology

Medical City Dallas defined the population that will be directly impacted by the project as patients receiving a psychiatric consult. To provide these consults, psychiatric specialists will need to be secured and available 24/7. The estimate value is $1,825,000 for 5 years of the project based on daily value of $1,000. Additional 5 year values for resources needed for the project include 1) administrator $500,000 2) staff $300,000, 3) IT equipment , IT resources and IT lines $1,000,000, and 4) training $83,000. In addition, it is projected 91 Behavioral Health/Substance abuse admission will be avoided. These are valued at $170,898 based on internal cost per admission of $1,878.

An additional 15% value was added for overhead for administering the program (CEO time, Medical staff etc.), $584,470.

The remainder of $6810 for total value was added to balance total funding.

Another approach for project value was reviewed based on estimated DY3, DY 4 and DY 5 additional capacity from timely discharge resulting from telemedicine consults (DY3-1500, DY 4-2300, DY5-2400). We estimated additional visits of 12,400 were would be possible from decreased holding and turn around time for ED visits. We used the average contribution margin for Medicaid visit from internal data of $360/ per visit for a total of $4,464,000. We believe this supports the overall valuation of $4,471,278.

The total value of the project then was estimated at $4,471,278. Approximately 80.65% of the total value was assigned to Category 2 project ($3,606,157) and the remaining 19.34% of value assigned to Category 3 outcome for Behavior Health/Substance abuse Admission Rate ($865,121).

Rationale/Justification: Behavioral health outcome improvement targets are dependent on the target population served (behavioral health), size (e.g. if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (boarded in ED/placing patients under observation instead of admitting them due to lack of behavioral health services).

020943901.1.2	***1.7.1***	*1.7 (E-F)*	*Implement a Telepsychiatry program to improve Specialty Care Access for Behavioral Health*	
Medical City Dallas				*020943901*
Related Category 3 Outcome Measure(s):	*020943901.3.4*	*3 IT 2.4*	*Behavioral Health/Substance Abuse 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)**
Milestone1 [P-X] Conduct needs assessment to identify volume / baseline of patients that need a behavioral health consult that can be provided via telemedicine Metric 1 [P-X]: Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel. a. Submission of completed patient needs assessment Data Source: Patient Needs Assessment Baseline: 1000 consults estimated for telemedicine Milestone 1 Estimated Incentive Payment: $881,938	**Milestone 2** [P-3]: Implement or expand telemedicine program for selected medical specialties, based upon regional and community need. Metric 1 [P-3.1.]: Documentation of program materials - implementation plan, vendor contracts, staff training, HR documents Goal: Implement Data Source: Program materials Milestone 2 Estimated Incentive Payment: $481,073 **Milestone 3 [P-X]:** Conduct continuous quality improvement activities for Telemedicine program Metric 1 [P-X]: Submission of Process Improvement Project Plan Data Source: Telemedicine Process Improvement Project Plan Milestone 3 Estimated Incentive Payment: $481,074	**Milestone 4** [I-X]: Increase number of telemedicine consults for each specialty identified as high need Metric 1 [I-X]: Number of telemedicine consults Goal: 2,300 consults Data Source: Telemedicine Registry Milestone 4 Estimated Incentive Payment: $482,472 **Milestone 5** [I-X]: Reduce wait times Metric 1 [I-X]: Time from consult order to patient discharge. Goal: decrease 15% improvement from baseline Data Source: Telemedicine Registry Milestone 5 Estimated Incentive Payment: $482,472	**Milestone 6** [I-X]: Increase number of telemedicine consults for each specialty identified as high need Metric 1 [I-X]: Number of Telemedicine consults Baseline/Goal: 2,400 consults Data Source: Telemedicine Registry Milestone 6 Estimated Incentive Payment: $398,564 **Milestone 7** [I-X]: Reduce wait times Metric 1 [I-X]: Time from consult order to patient discharge. Goal: decrease 25% improvement from baseline Data Source: Telemedicine Registry Milestone 7 Estimated Incentive Payment: $398,564
Year 2 Estimated Milestone Bundle Amount: $881,938	Year 3 Estimated Milestone Bundle Amount: $962,147	Year 4 Estimated Milestone Bundle Amount: $964,944	Year 5 Estimated Milestone Bundle Amount: $797,128
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,606,157			

Project Option 1.1.1- Establish more primary care clinics
(Expand Primary Care for Pediatrics by establishing a new clinic)

Unique Project ID: 020943901.1.3
Performing Provider Name/TPI: Medical City Dallas/020943901

Provider: Medical City Dallas is a 586 -bed acute care hospital in Dallas, Texas serving a Primary and Secondary Service Area population of approximately 3.2 million. Medical City Dallas operations include pediatric services with a dedicated 11 bed Pediatric Emergency Room, 60 bed Pediatric Med/Surg unit, 20 bed Pediatric Intensive Care Unit and 55 bed Neonatal Care Intensive Care unit.

Intervention(s): This project will establish a pediatric clinic in the north Dallas area to provide access to pediatric care for preventative and primary care.

Need for the project: Currently pediatric providers in the region have limited the number patients or do not accept Medicaid/CHIP patients. The current pediatric physician demand is more than 80% of the current supply. In Dallas County alone, over 36.2% of children were enrolled in Medicaid in 2010, exacerbating the issue of availability of primary care access and treatment.

Target population: The target population is Medicaid/CHIP and uninsured pediatric patients that need a primary care provider and medical home. Approximately 90% of patients referred to the clinic will either Medicaid eligible or indigent.

Category 1 or 2 expected patient benefits: The project seeks to provide 4,000 patient visits in DY4 and 6,000 in DY5 by providing a medical home to patients in DY1-0, DY2-500, DY 3-1,000, DY4-2,000 and DY5 3,000

Category 3 outcomes: IT-9.3 Our goal is to reduce the Pediatric/Young Adult Asthma Emergency Department Visits by 15% by DY5. In DY3-5% ,DY4-15%, DY5- 15% for a total 35% reduction from total baseline visits of 1100. We expected to reduce the rate of Medicaid and indigent patients (715 visit a year) by 55%,393 visit per year (which 35% of total visits,1100).

Project Description

Medical City Dallas will partner with PediPlace, a nonprofit organization to establish a new pediatric primary care outpatient clinic in the North Dallas area. This clinic will open with 2 medical providers and staff to see Medicaid/CHIP and uninsured pediatric patients. Medical City will develop a referral process for patients from ED for primary care and from the main hospital for newborn care. This will support patients for appropriate follow up care and have access to a provider for well child preventative visits.

The clinic will be located at a site in the North Dallas area based on:

1. zip codes of patient seen in ED and newborns for Medicaid and Uninsured
2. Pediatric providers availability in the area
3. Transportation access and other service availability (WIC, Public health etc)

Once a site is located and secured, detail planning for operations will begin. It is projected to take 6-9 months to open the clinic once a site is secured. Planning and development will include space build-out, EMR, staff hiring and training and in addition to recruiting 2 Nurse Practitioners. The clinic will have the capacity for 3-4 providers in total, so in the future additional providers and/or hours can be added.

As part of the referral process, Medical City Dallas will track and follow up with patients to see if they have utilized primary care services at Pedi Place. The clinic will also operate various programs to serve as a medical home for patients and families. These include the Illness to Wellness Program for children with acute and chronic diseases, Healthy Babies and Healthy Kids programs for preventive care, and appropriate parent education about providing proper care to new born children and proper instruction on how to and when to access services, particularly during a child's first two years.

Goals and Relationship to Regional Goals:

The goal of this project is to increase pediatric clinic sites and providers for Medicaid/CHIP and Uninsured patients in the North Dallas area. This will establish a medical home for patients with acute and chronic conditions so they diagnosed and treated early, resulting in less hospitalizations and specialty care. Providing families with a medical home will allow them to bring their children to a friendly, familiar place for routine preventative care, immunizations, and a comforting helpful facility when they are sick.

We believe we can reduce Emergency room visits for all pediatrics including those with asthma, and increase well child care for newborns.

Regional goals include having better health outcomes and reduced health cost. This project creates a pediatric medical home, to provide primary care and preventive well baby care. Improved primary care and preventative care will result in better health outcomes and reduced cost from less Emergency room visits resulting in the right care in the right setting.

Challenges

One of the challenges faced for pediatric patients is ensuring primary care availability. Currently pediatric providers have limited their panel of Medicaid/CHIP patients and fees for uninsured patients are a huge barrier leaving a gap in service to low income populations.

5-Year Expected Outcome for Provider and Patients

By the end of the waiver period, we expect to have 3,000 unique patients who will have a medical home at the clinic.

Starting Point/Baseline

The clinic would not open until mid-2013, so baseline would be established in DY 2.

Rationale

The community needs assessment identification CN. 4 Primary Care and Pediatrics support this project. The current pediatric physician demand is more than 80% of the current supply. In Dallas County alone, over 36.2% of children were enrolled in Medicaid in 2010, exacerbating the issue of availability of primary care access and treatment. The capacity for pediatric primary care is further limited by the decline in pediatricians accepting Medicaid patients. Adding a new pediatric provider at a site that is closer to patients in the North Dallas area would be increase capacity to serve the Medicaid/CHIP and Uninsured patients

Project Option

Medical City sees over 3,600 level 4 and 5 visits for Medicaid/CHIP and Uninsured patients each year. However we believe the percent of visits to the Emergency Room that are Non-Emergent, Emergent but Primary care Treatable or Emergent but Preventable is much higher. Adding a primary care clinic for this patient population will reduce need for seeking treatment in emergency room.

This clinic will also provide comprehensive newborn care. Well child preventive visits for children ages three days – fifteen months are very important to both child and parent. The American Pediatric Society recommends that children receive eight well-child exams in their first fifteen months to monitor early development, receive timely recommended immunizations, educate parents and caregivers, and to allow for early diagnosis of medical issues if they occur.

Project Components

The clinic will be new clinic located in North Dallas area. It will be staffed by 2 medical providers dedicated to this clinic location as well as support staff. Strategic planning has occurred to identify primary care gaps and possible locations for the clinic that would best serve patients in need. Once a location is found, planning and implementation will start to open the clinic in 6-9 months. Hiring and training of staff will be necessary as well as. Patients will be referred from Medical City Dallas but the clinic will see any patients referred to their services regardless of financial status.

Unique Community Need Identification Numbers the Project Addresses

The community need identification number this project addresses is CN.4 Primary Care and Pediatrics. As documented in the Community Needs Assessment for RHP 9, the current pediatric demand is more than 80% of the current supply. In Dallas County alone, over 36.2% of children were enrolled in Medicaid in 2010, exacerbating the issue of availability of primary care access and treatment. Medical City Dallas pediatric emergency room provides are for 3,600 urgent care level visits each year with limited referral capacity for patients who need care in a more appropriate and cost effective setting.

How the Project represents a new initiative

Medical City does not currently have a clinic site for pediatric care in this service area. This clinic will enhance delivery system by increasing pediatric provider for low income populations and improving their health outcomes with preventative care.

Related Category 3 Outcome Measure(s)

This project will impact outcome IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381. It is important for the region to improve ED utilization as patients have had to utilize most the costly setting for care due to lack of access to primary and preventative care. By providing a primary care provider and medical home to pediatric asthma patients along with patient and caregiver education in asthma management will help reduce asthma morbidity in children and decrease the substantial costs of pediatric asthma. The majority of patients being served by this project qualifies for Medicaid/CHIP or is uninsured. Improving asthma outcomes for these patients will improve health of low-income populations.

Relationship to other projects

This project supports the reduction of 020943901.4.2 RD-1 Potentially Preventable Admissions (Pediatric Asthma) and 029043901.4.3 RD-2 30 Day readmissions (Pediatric Asthma) by providing a medical home to patients with acute disease.

Relationship to other Performing Providers in the RHP and Plan for Learning Collaboratives:

The following providers are also proposing projects to address pediatric primary care clinics:

- Children's Dallas 138910807.1.1

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may

enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology:
Medical City Dallas defined the population that will be directly impacted by the project as patients receive a medical home at the pediatric clinic and those patients with pediatric asthma. There were 2 measures used for this project valuation, patient provided a medical home and pediatric/young adult emergency room visits. The population expected to be positively impacted by the project for primary care and medical home is 3,000 patients by DY 5, (DY3-1000, DY 4-2000, DY5- 3000). The estimated pricing for medical home was $650 per year per patient. This value was obtained from averages of various PCMH studies (Intermountain Healthcare, Blue Cross Blue Shield, etc.) The value is based on investing in primary care patient centered medical homes resulting in improved quality of care and patient experiences and costs compared to non-PCMH patients and reductions in expensive hospital and emergency department utilization. This totaled approximately $3,900,000 for 5 years.
The population expected to be positively impacted by the project for reduction in pediatric/young adult asthma patients is 385 visits by DY 5. The estimated cost for a pediatric/young adult ED visits from internal data is $1210. This totaled approximately $465,850

The remainder of $1,896 for total value was added to balance total funding.
The total value of the project then was estimated at $4,367,746. Approximately 80.63% of the total value was assigned to Category 2 project ($3,521,529)and the remaining 19.37% of value assigned to Category 3 outcome for Pediatric/Young Adult ED Visits ($846,217).

Rationale/Justification: Outcome improvement targets are dependent on the target population served and also current processes in place that already prevent avoidable ED visits and hospitalizations.

020943901.1.3	***1.1.1***	***N/A***	***ESTABLISH MORE PRIMARY CARE CLINICS***	
Medical City Dallas				*020943901*
Related Category 3 Outcome Measure(s):	*020943901.3.5*	*3 IT 9.3*	*Pediatric/Young Adult Asthma Emergency Department Visits-NQF 1381*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Establish additional/expand existing/relocate primary care clinics Metric 1 [P-1.1]: Number of additional clinics Goal:: Open clinic Data Source: New schedule Milestone 1 Estimated Incentive Payment *(maximum amount):* $430,620 **Milestone 2** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric 1 [P-5.1]: Documentation of increased number of providers/ staff Goal: train 100% staff and providers Data Source: documentation from training logs and HR Milestone 2 Estimated Incentive Payment: $430,621	**Milestone 3** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1.]: Documentation of increased number of visits. Goal: Increase visits to 2,000 Data Source: EHR and scheduling system Metric 2 [I-12.2.]: Documentation of increased number of unique patients, or size of patient panels Goal: Increase unique patients to 1000 Data Source: EHR. and scheduling system Milestone 3 Estimated Incentive Payment: $939,568		**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: Increase visits to 4,000 Data Source: EHR and scheduling system Metric 2 [I-12.2.]: Documentation of increased number of unique patients, or size of patient panels Goal: Increase unique patients to 2000 Data Source: EHR. and scheduling system Milestone 4 Estimated Incentive Payment: $942,2995	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1.]: Documentation of increased number of visits. Goal: Increase visits to 6,000 Data Source: EHR and scheduling system Metric 2 [I-12.2.]: Documentation of increased number of unique patients, or size of patient panels Goal: Increase unique patients to 3000 Data Source: EHR. and scheduling system Milestone 5 Estimated Incentive Payment: $778,421
Year 2 Estimated Milestone Bundle Amount: $861,241	Year 3 Estimated Milestone Bundle Amount: $939,568		Year 4 Estimated Milestone Bundle Amount: $942,299	Year 5 Estimated Milestone Bundle Amount: $778,421
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,521,529				

Project Option 1.1.2 – Expand Primary Care Capacity – Grand Prairie Clinic

Unique Project ID: 127295703.1.1

Performing Provider Name/TPI: Parkland Health & Hospital System/TPI 127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. While Parkland's overall payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare and 7% Commercial Insurance, the Community Oriented Primary Care (COPC) clinic network's payer mix includes 62% Charity/Self Pay and 20% Medicaid.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY2012 Volumes	Parkland Share of Dallas County Adults	
		% Total Adult	Medicaid/ Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Centers	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Parkland directly employs approximately 150 primary care physicians (pediatrics, family medicine, internal medicine) who provide services in the community health centers. Campus based physician services are provided mainly by UT Southwestern Medical Center faculty under a services contract.

Intervention: Expand primary care capacity for low income/indigent patients by rapidly scaling up operations at the newly opened Community Oriented Primary Care clinic (COPC) in Grand Prairie in Dallas County.

Need for the Project: There is a significant population (65,000 individuals) in Grand Prairie, Texas living at or below 200% of poverty level. There are limited primary care resources available to serve this population. By making primary care services available in a recognized medical home model, this vulnerable population will have access to services that can prevent illness, assist in the management of chronic disease, support episodic illnesses and contribute to the wellbeing of the community and the patients it serves.

Target Population: This clinic will serve residents of Grand Prairie (approximately 65,000 area residents) with income levels at or below 200% poverty.

Category 1 & 2 Expected Patient Benefits: Improved access to primary care services for patients in the Grand Prairie area (of Dallas County) as follows:

Volume	DY1	DY2	DY3	DY4	DY5
Baseline (FY 10.31.11)	1,889 (7,556 annualized)				
Additional visits		7,500	12,000	12,000	4,000
Cumulative additional visits		7,500	19,500	31,500	35,500
Cumulative annual visits	1,889	9,389	21,389	33,389	37,389

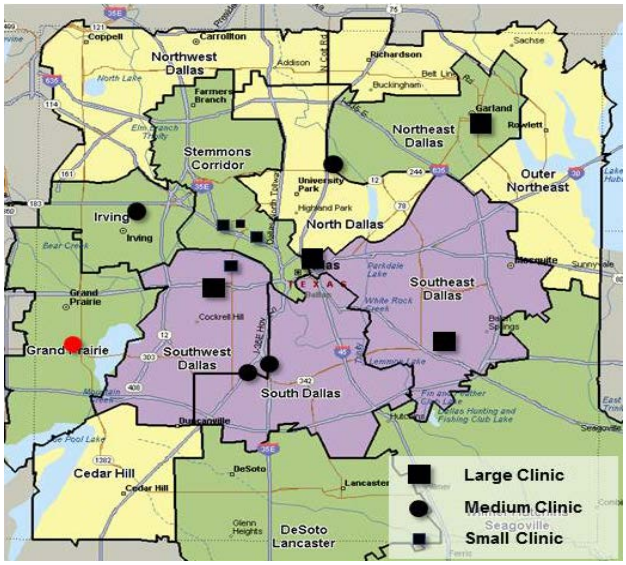
Category 3 Outcomes: The FY2016 outcomes for this project include the following:

- IT-1.2: Annual monitoring for patients on medications: ACE inhibitors or ARBS
    - Goal is to increase number of monitored patients
        - CHF: 83.7% (605 patients in FY12) to 88%;
        - Diabetes: 82.5% (2,282 patients in FY12) to 88%
- IT-1.12: Diabetes care: Retinal Eye Exam. Goal is to increase number of COPC patients who receive from 0 to 3,000
- IT-1.20: Other - % patient who by age 13 years up-to-date with recommended immunizations: 1) MCV4 and 2) one Tdap/Td. Goal to increase to 80% compliance. (1,617/2,456 = 66% compliance in FY2012)

Project Description

Parkland currently provides services in twelve Community Oriented Primary Care (COPC) health centers and eleven Youth and Family centers. Based on a study of demographics, existing provider availability and community need, Parkland planned and developed a new clinic in Grand Prairie, Texas to provide scheduled primary and preventive care services as well as same-day services via the Today Clinic model. The clinic was opened at a base staffing level in

June 2012 and at its maximum capacity could expand the existing Parkland community clinic system by more than 35,500 annual visits or nearly 8%.



As depicted in the Dallas County markets map, the Grand Prairie market segment is located on the western border of Dallas County consisting of three zip codes: 75050, 75051 and 75052. The roadway system and Mountain Creek Lake serve as natural barriers to services located to the east of the market segment. Accordingly, the residents of Grand Prairie are relatively geographically isolated from the existing Parkland system community resources noted by the black markers on the map. The new Grand Prairie clinic (denoted by the red circle) is centrally located in the market segment and provides good access to all residents.

In 2010, of the approximate 170,000 residents of the Grand Prairie market segment, about 40 percent or nearly 65,000 have incomes placing them below 200% of poverty. It is this population that this project is intended to serve. This project proposes to extend Parkland's primary care system model to serve this target market by enabling the Grand Prairie clinic to rapidly scale up its operations to its full capacity. The clinic will provide adult, pediatric and women's (initially maternal and family planning) primary care services and has the capacity to provide approximately 35,000-40,000 visits. Based on historic system experience, this would translate into service to approximately 14,000 – 16,000 new individual patients.

Goals and Relationship to Regional Goals

This project aligns directly to address the primary care capacity need identified in the Community Needs Assessment and specifically places the new primary care capacity in a location where existing primary care resources are in short supply and where natural barriers present access challenges to existing Parkland system resources. Further, this project aligns directly with the RHP 9 goal of improving access to health care services.

Challenges

As presented in the Community Needs Assessment, the State and region in which RHP 9 resides has significant shortages of primary care physicians. The rapid service scale-up envisioned by the project will challenge the system's physician and clinical staff recruitment efforts. However, Parkland has a well-established recruitment process and pipeline that should alleviate the recruitment challenges.

5-Year Expected Outcome for Providers and Patients

This project will provide a significant and valuable new primary care resource to the Grand Prairie market segment. By DY5, the clinic will be serving between 14,000 and 16,000 individuals and providing 35,500 new primary care visits. This project will provide a continuous source of primary care in a practice recognized as a primary care medical home. Patients will receive preventive, chronic disease management and same-day responsive services.

Starting Point/Baseline

Parkland opened Grand Prairie in June 2012 and in three months provided 1,889 visits. The baseline for this project is set at 1,889 visits (annualized 7,556) for FY2012 (October 1, 2011-September 30, 2012).

Rationale

In Dallas County as elsewhere, low income, uninsured, and minority populations disproportionately lack access to care. Dallas County has more than one million residents living at or below 200% poverty many of whom have very limited access to health services.[123] Parkland is the largest provider of care for the medically indigent in the region; however, the system is at capacity constraining care throughout the continuum including primary care clinics, the ED and the specialty clinics. Access to primary care services is demonstrated to offer a lower cost model for prevention, health maintenance, chronic disease management and episodic condition management. It supports the reduction of emergency service use for non-emergent conditions and contributes to reductions in readmission rates.

How this project significantly enhances an existing care delivery reform initiative

By introducing 35,500 new primary care visits, this project directly supports the need for expanded primary care services for the low income patient population in Grand Prairie. This new access will also provide access to a system of care including a primary care medical home through which same day appointments, episodic and chronic disease management services will provide a comprehensive system of primary care.

The project has no related activities funded by U.S. Department of Health & Human Services.

Project components

Required core components for Project Option 1.1.2 are as follows:

[123] US Census Bureau.*2009 American Community Survey.* http://www.census.gov/acs/www/data_documentation/summary_file/

a) Expand primary care clinic space. *This was a new clinic built in 2012 and sized for approximately 35,000-40,000 visit capacity at maturity. Through this project, the clinic will rapidly scale up its operations to the clinic's capacity*

b) Expand primary care clinic hours. *The scheduled slots will increase through the scale – up making expanded scheduled appointment time available. The hours of operation will be adjusted to meet demand.*

c) Expand primary care clinic staff. *New staff will be hired to support scaled-up operations.*

Milestones and Metrics

- P-1: Establish additional/expand existing/relocate primary care clinics
  - P-1.1: Number of additional clinics, expanded hours or space
- P-5: Train/hire additional primary care providers and staff and/or increase number of primary care clinics for existing providers
  - P-5.1: Documentation of increased number of providers, staff and/or clinic sites
- I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services
  - I-12.1: Documentation of increased number of visits

Unique community need identification numbers the project addresses

- *CN.4 – Lack of Primary Care and Pediatric Care*

Related Category 3 Outcome Measure(s)

OD-1: Primary Care and Chronic Disease Management

- IT-1.2: Annual monitoring for patients on persistent medications: ACE inhibitors or ARBS for CHF and Diabetes patients
- IT1.12: Diabetes care: Retinal eye exam – NQF 0055
- IT-1.20: Other NQF 1407 - Percentage of patients who by age 13 years were up-to-date with recommended adolescent immunizations: MCV4 and Tdap/Td

Reasons and rationale for selecting outcomes

The tasks for primary care providers are many, including but not limited to – medication management for persistent mediations, appropriate preventive services for chronic disease such as retinal scanning for diabetics and preventive services for adolescents.[124] Among other

[124] American Diabetes Association, Position statement: standards of medical care in diabetes - 2012 Diabetes Care, 2012. 35 (Supp 1): p. S11-S63.

chronic disease and acute care issues, this project will specifically address diabetes retinal exams, monitoring for patients on ACE inhibitors or ARBs, and preventive services for children and adolescents (patients who by age 13 years were up-to-date with recommended adolescent immunizations NQF 1407).

Annual monitoring for patients on persistent medications (ACE inhibitors or ARBS). Congestive heart failure (CHF) and diabetes are our most common diagnoses, resulting in a significant number of patients on chronic medications needing to be monitored to decrease risk of adverse drug events from long-term medication use or misuse of medications. Persistent use of ACE Inhibitors or ARBs warrants monitoring and follow-up by the medical home to assess for side-effects, particularly loss of kidney function, and adjust drug dosage/therapeutic decisions accordingly.[125] The costs of annual monitoring are then offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications[126].

Diabetes: Retinal Eye Exam. Diabetic retinopathy, one of the leading causes of blindness in adults, can be treated if detected and addressed in the early stages.[127] Medical teams, using the Wagner Chronic Care Model, will ensure patients with diabetes receive retinal eye exams. Additionally, patients with diabetes who will have access to primary and preventive care that can be coupled with other Parkland services including ADA-certified diabetes self-management classes and pharmacy services provided by pharmacists who are certified diabetes educators.

Primary Care and Prevention: Adolescent Immunizations. Vaccines recommended for children ages 11-12 by the American Academy of Pediatrics, the American Academy of Family Medicine, the Centers for Disease Control and Agency for Healthcare Research and Quality include:

- TDaP vaccine which protects against tetanus, diphtheria and pertussis[128]
- Meningococcal conjugate vaccine, which prevents meningococcal disease (10-14% of invasive meningococcal infections are fatal, and 11-19% result in long-term disability such as deafness, brain damage, or an amputated arm or leg[129]; in the U.S., prevalence of invasive meningococcal disease peaks in infants, with a second peak in adolescents[130])

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[125] Jessup, M., et al., *2009 focused update: ACCF/AHA guidelines for the diagnosis and management of heart failure in adults: a report of American College of Cardiology Foundation/American Heart Association Taks Force on Practice Guidelines: developed in collaboration with the International Society for Heart and Lung Transplantation.* Circulation, 2009. **119**(14): p. 1977-2016.

[126] Briggs, A., et al., *Cost effectiveness of perindopril in reducing cardiovasular events in patients with stable coronary artery disease using data from the EUROPA study.* Heart, 2007. **93**: p. 1081-1086.

[127] American Optometric Association. *Diabetes is the leading cause of blindness among most adults*. 2012 [cited 2012 Oct 19]; Available from: http://www.aoa.org/x6814.xml

[128] American Optometric Association. *Diabetes is the leading cause of blindness among most adults*. 2012 [cited 2012 Oct 19]; Available from: http://www.aoa.org/x6814.xml

[129] US Department of Health and Human Services, C.f.D.C.a.P., *Prevention and control of meningococcal disease: rcommendation of the Advisory Committee on Immunization Practices (ACIP).* Morbidity and Mortality Weekly Report, Recommendations and Reports, 2005. 54(RR07): p. 1-21.

[130] Judelsohn, R., Marshall, G.S., *The burden of infant meningococcal disease in the United States.* Journal of the Pediatric Infectious Diseases Society, 2011. **1**(1): p. 64-73.

Relationship to other Projects

This project expands primary care access for the indigent in Dallas County. Parkland intends to balance the care continuum to insure those patients who need a medical home and/or require care through a chronic care model have access and also assure that the patients who do not need a medical home but require occasional medical care also receive the care they need in the right setting. All Parkland projects address a key component of the care continuum that must be addressed to find the right balance. This balance will insure all patients get the right care at the right time in the right place. Specific projects related to primary care access include the following:

Unique Project	Project Option	Project Description
127295703.1.2	1.1.2	Expand existing primary care capacity
127295703.1.6	1.1.1	Establish new primary care clinic – Acute Response Clinic
127295703.2.1	2.1.1	Expand Medical Home model
127295703.2.4	2.2.1	Expand chronic care management model

Category 4 related outcomes

- RD-2: Potentially Preventable Readmissions for CHF and Diabetes
- RD-5: Emergency Department
- RD-6: Optional Initial Core Set of Health Care Quality Measures for screenings
    - Annual monitoring for patients on persistent medications
    - Diabetes Care

Relationship to other Performing Providers' Projects and Plan for Learning Collaborative

Other performing provider projects that focus on expanding primary care capacity (Project Option 1.1) include:

Unique Project	Performing Provider
195018001.1.1	Baylor Medical Center at Carrollton (Trinity)
121790303.1.1	Baylor Medical Center at Garland
121776204.1.1	Baylor Medical Center at Irving
139485012.1.1	Baylor University Medical Center
138910807.1.1	Children's Medical Center
138910807.1.2	Children's Medical Center
020943901.1.3	Medical City Dallas (HCA)
020908201.1.1	Texas Health Presbyterian Hospital Dallas
126686802.1.1	UT Southwestern Medical Center Faculty Plan
126686802.1.2	UT Southwestern Medical Center Faculty Plan

Parkland plans to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Parkland adopted the RHP 9 global method to project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 8.10 on a scale of 9.0. Influencing factors included:

- The large impact this project will have on the Grand Prairie low income population by introducing capacity growth of 40,000 visits over the five years of the project
- Alignment with the community need for primary care capacity expansion
- Cost avoidance providing increased opportunity for patients in this community to obtain the right care in the right place at the right time
- This project is targeted to serve the 65,000 residents of Grand Prairie with income levels less than 200% of poverty.

Benefits of primary care include: prevention, early intervention, fewer preventable ER visits, fewer hospital admissions, improved outcomes, reduced mortality, increased trust and treatment compliance.[131] These benefits have been demonstrated to associate with lowering costs of care from between 20 and 33 percent.[132]

The following sketches the potential range of value that could be produced through the expansion of primary care as contemplated by this project. From this broad reasonableness review, this project value is demonstrated to fit below the comparative value range.

[131] Robert L Phillips, Jr. and Andrew W. Bazemore; Primary Care And Why It Matters For U.S. Health System Reform; *Health Affairs*, 29, no.5 (2010):806-810

[132] American College of Physicians. "How Is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?" Philadelphia: American College of Physicians; 2008: White Paper.

	DY2	DY3	DY4	DY5	Total
Incremental visits from baseline	7,500	19,500	31,500	35,500	11,950-14,000
Estimated cumulative incremental patients (2.74 visits per patient)	2,730	7,120	11,510	12,975	
Estimated per capita costs[133]	$8,952.8	$9,807.5	$10,327.3	$10,874.6	
Estimated target population cost	$24,441,144	$69,829,400	$118,867,223	$141,097,935	$354,235,702
Range of Potential Cost Reductions (20-33%)[134,135]					$70,847,140 – $116,897,782
Project Valuation (Cat 1 + assoc. Cat 3)					$36,489,469

[133] Sean P. Keehan, Gigi A. Cuckler, Andrea M Sisko, Andrew J. Madison, Sheila D. Smith, Joseph M. Lizonitz, John A. Posal and Christian J. Wolfe; National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands and Economic Growth Accelerates; Health Affairs, 31, no. 7 (2012): 1600-1612

[134] Mark DH, Gottlieb MS, Zellner BB, Chetty VK, Midtling JE. Medicare costs in urban areas and the supply of primary care physicians. J Fam Pract. 1996 Jul; 43(1): 33-39.

[135] Franks P, Fiscella K. Primary care physicians and specialists as personal physicians. Health care expenditures and mortality experience. J Fam Pract. 1998 Aug; 47(2):105-109.

Unique Identifier: *127295703.1.1*	***RH PPP Reference:*** *1.1.2*	***Project Components:*** *NA*	***Title:*** *Expand Primary Care Capacity –Grand Prairie*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.1* *127295703.3.2* *127295703.3.3*	*3.IT-1.2* *3.IT-1.12* *3.IT-1.20*	- Annual monitoring for patients on medications: ACE inhibitors or ARBS - CHF & Diabetes patients - Diabetes care: Retinal eye exam – NQF 0055 - Other: % patients by 13 years are up-to-date w/recommended immunizations: MCVS4 & Tdap/Td

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Establish additional/expand existing/relocate primary care clinics Metric 1 [P-1.1]: Number of additional clinics, expanded hours or space Goal: Ramp up new clinic Data Source: New primary care schedule or other documentation Milestone 1 Estimated Incentive Payment: $ 3,750,508 **Milestone 2** [I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 2 [I-12.1]: Documentation Baseline DY1: 1,889 visits (7,556 annualized) Goal: 9,389 visits Data Source: Statistics Report Milestone 2 Estimated Incentive Payment: $ 3,750,508	**Milestone 3** [P-5] Train/hire additional primary care providers and staff and/or increase number of primary care clinics for existing providers Metric 3 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites Goal: Increase staff/providers as determined in HR plan for clinic Data Source: Report, policy, contact Milestone 3 Estimated Incentive Payment: $3,835,877 **Milestone 4** [I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 4 [I-12.1]: Documentation of increased number of visits Baseline DY1: 1,889 visits (7,556 annualized) Goal: 21,389 visits Data Source: Statistics Report	**Milestone 5** [I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 5 [I-12.1]: Documentation of increased number of visits Baseline DY1: 1,889 visits (7,556 annualized) Goal: 33,389 visits Data Source: Departmental Statistics Report Milestone 5 Estimated Incentive Payment: $7,659,861	**Milestone 6** [I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 6 [I-12.1]: Documentation of increased number of visits Baseline DY1: 1,889 visits (7,556 annualized) Goal: 37,389 visits Data Source: Departmental Statistics Report Milestone 6 Estimated Incentive Payment: $6,184,981

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127295703.1.1</td><td>RH PPP Reference:
1.1.2</td><td colspan="2">Project Components:
NA</td><td colspan="2">Title: Expand Primary Care Capacity –Grand Prairie</td></tr>
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<tr><td>Related Category 3 Outcome Measures:</td><td>127295703.3.1
127295703.3.2
127295703.3.3</td><td>3.IT-1.2
3.IT-1.12
3.IT-1.20</td><td colspan="3">- Annual monitoring for patients on medications: ACE inhibitors or ARBS - CHF & Diabetes patients
- Diabetes care: Retinal eye exam – NQF 0055
- Other: % patients by 13 years are up-to-date w/recommended immunizations: MCVS4 & Tdap/Td</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th colspan="2">Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th colspan="2">Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td></td><td colspan="2">Milestone 4 Estimated Incentive Payment: $3,835,878</td><td></td><td colspan="2"></td></tr>
<tr><td>Year 2 Estimated Milestone Bundle Amount: $7,501,016</td><td colspan="2">Year 3 Estimated Milestone Bundle Amount: $7,671,755</td><td>Year 4 Estimated Milestone Bundle Amount: $7,659,861</td><td colspan="2">Year 5 Estimated Milestone Bundle Amount: $6,184,981</td></tr>
<tr><td colspan="5">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):</td><td>$29,017,613</td></tr>
</table>

Project Option 1.1.2 – Expand Existing Primary Care Capacity

Unique Project ID: 127295703.1.2

Performing Provider Name/TPI: Parkland Health & Hospital System/TPI 127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. While Parkland's overall payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare and 7% Commercial Insurance, the Community Oriented Primary Care (COPC) clinic network's payer mix includes 62% Charity/Self Pay and 20% Medicaid.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY2012 Volumes	Parkland Share of Dallas County Adults	
		% Total Adult	Medicaid/ Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Centers	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Parkland directly employs approximately 150 primary care physicians (pediatrics, family medicine, internal medicine) who provide services in the community health centers. Campus based physician services are provided mainly by UT Southwestern Medical Center faculty under a services contract.

Intervention: Expand hours and increase staff and space at select the COPC clinics (Vickery, DeHaro, Garland, and Youth and Family locations) to provide additional access for low income/indigent patients.

Need for the Project: There is significant unmet need for primary care services for the indigent in Dallas County. There are more than one million in Dallas County with income levels at or below 200% FPL (Federal Poverty Level). This project will make a substantial contribution to the new primary care visit capacity in Dallas County. The value of the additional access is leveraged because it will be provided through extended hours of operation provided greater flexibility and convenience to the patients served.

Target Population: The target population includes more than one million residents of Dallas County with income levels at or below 200% FPL, particularly those patients in the catchment areas of De Haro, Garland and Vickery clinics and the Youth & Family (Y&F) clinics. Currently those clinics provide more than 138,000 visits per year.

Category 1 & 2 Expected Patient Benefits: This project will improve access to primary care services for patients with incomes less than 200% FPL in the catchment area of the specified clinics (De Haro, Garland, Vickery and Y&F) by 14,000 visits, broken down as follows:

Volume	DY1	DY2	DY3	DY4	DY5
Baseline (FY 10.31.11)	139,042				
Additional visits		0	7,000	7,000	6,000
Cumulative additional visits		0	7,000	14,000	20,000
Cumulative annual total visits	139,042	139,042	146,042	153,042	159,042

Category 3 Outcomes: The FY2016 outcomes for this project include the following:

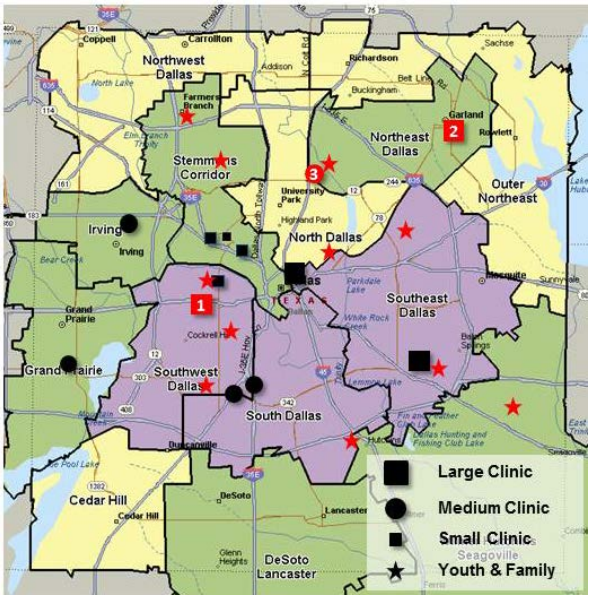
- IT-1.2: Annual monitoring for patients on medications: ACE inhibitors or ARBS
    - Goal is to increase number of monitored CHF and Diabetes Patients
        - CHF: 83.7% (605 patients in FY12) to 88%;
        - Diabetes: 82.5% (2,282 patients in FY12) to 88%
- IT-1.12: Diabetes care: Retinal Eye Exam. Goal is to increase number of COPC patients who receive from 0 to 3,000
- IT-1.20: Other - % patient who by age 13 years up-to-date with recommended immunizations: 1) MCV4 and 2) one Tdap/Td. Goal to increase to 80% compliance. (1,617/2,456 = 66% compliance in FY2012)

Project Description

Expand Parkland's primary care capacity throughout the Community Oriented Primary Care (COPC) network for low income/indigent patients in Dallas County.

Parkland currently provides services in twelve Community Oriented Primary Care (COPC) health centers and eleven Youth and Family centers. This year, Parkland opened a new clinic at the Grand Prairie location and in addition to rapidly scaling up that clinic (127295703.1.1) Parkland has identified the following clinics for expansion of hours, staff and/or space:

- De Haro: recruitment of 1.5 FTEs and 1100 square feet expansion of clinic space
- Garland: recruitment of 2 FTEs
- Vickery: recruitment of 1.2 FTEs and expansion of evening hours of operation
- Youth and Family Centers (school-based) – open 1 clinic and expand hours for 2 others



The adjacent map (Dallas County markets) provides an overview of clinic sites. This expansion serves the Dallas County community, targeting those whose income levels fall below 200% FPL, through improved access to primary care and improved management of chronic disease for the low income/indigent population. Additional staff will provide the capacity to extend hours into evenings and weekends opening more appointment times.

Goals and Relationship to Regional Goals

The goal of this project aligns with the regional goal of increasing access. The expansion of service hours as well as adding providers and staff will increase appointment availability reducing unnecessary emergency department utilization. To increase capacity within the COPC network, this project intends to achieve the following:

- Increase staff, hours of operation and space accommodations for identified primary care clinics to provide an additional 14,000 primary care visits (~10% increase)
- Expand access to same-day service through the Today Clinic model to see patients in a more appropriate setting for their acute health needs
- Incorporate the benefits of several additional projects the chronic care model (127295703.2.4), and the enhancement of the Primary Care Medical Home model (127295703.2.1).

Challenges

Challenges include recruitment of providers to staff clinics through extended hours as well as funding additional costs to insure other resources are available for extended hours. Several of the COPC clinics are in neighborhoods where crime is high and the safety of the patients and staff must be paramount when extending hours into evenings and on weekends. However Parkland is determined to insure additional access and will develop an implementation plan that will address the challenges.

Parkland will address physician shortages by recruiting more mid-level providers and encourage top-of-license performance to insure more patients are treated and that they are provided high quality care.

5-Year Expected Outcome for Providers and Patients

Parkland expects to add capacity sufficient to provide 14,000 additional primary care clinic visits by DY5 for the identified clinics with expansion initiatives.

In addition to increasing the number of patients who can be seen within the COPC primary care clinic system the utilization of a medical home model will provide more coordinated care for patients.

Starting Point/Baseline

In fiscal year 2012, Parkland provided 139,042 visits at the clinics identified for expansion:

- De Haro clinic visits: 53,025
- Garland clinic visits: 50,823
- Vickery clinic visits: 17,858
- Youth & Family clinic visits: 17,336

Total visits: 139,042

Because Parkland is balancing volumes among the COPC network to deal with desperate capacity constraints, it is difficult to determine volume goals by specific clinic at this time. As the ambulatory strategy is more refined, it may be possible to determine goals for each COPC clinic but currently the demand is far beyond the capacity and patients are directed as capacity is available.

Rationale

In Dallas County low income, uninsured, and minority populations disproportionately lack access to care. Dallas County has more than a million residents living at or below 200% poverty, many of whom have very limited access to health services.[136] Parkland is the largest provider of care for the medically indigent in the region; however, the system is at capacity, constraining care throughout the continuum including not only the primary care clinics but the ED and the specialty clinics. In coordination with other Parkland projects, this project will:

1) Increase access at a key entry point – primary care
2) Extend the primary chronic disease management throughout the health system
3) Establish comprehensive care management program that includes a standardized discharge planning process to insure patients are discharged to the appropriate post-acute care setting

[136] U.S. Census Bureau. *2009 American Community Survey*.http://www.census.gov/acs/www/data_documentation/summary_file/

Improve the quality of care provided through sepsis management, decreased readmission rates, improved clinical outcomes for potentially preventable complications, etc.

This project is designed to leverage the investment in new capacity by providing that capacity through extended hours of operation – to provide access in a manner that will provide enhanced convenience and flexibility to the patients served by this project.

How this project significantly enhances an existing care delivery reform initiative

More than 80% of the patient visits provided by the COPC network are for indigent patients and Medicaid beneficiaries. By introducing 14,000 new primary care visits, this project directly supports the need for expanded primary care services for the low income patient population in the neighborhoods already served by the Parkland community health system. Expanding hours, space and staff will provide access to a system of care including a primary care medical home through which same day appointments, episodic and chronic disease management services will provide a comprehensive system of primary care.

The project has no related activities funded by U.S. Department of Health & Human Services.

Project Components

The required project components addressed in this project include the following:

a. Expand primary care clinic space. *Space will be increased for De Haro and Youth & Family clinics.*
b. Expand primary care clinic hours. *Vickery and Youth & Family clinics will extend hours of operation into evenings and/or weekend*
c. Increase primary care clinic staffing. *Recruitment for additional providers (mid-levels) is in process for Vickery, De Haro, and Garland clinics*

Milestones and Metrics

- P-2: Expand community/school-based clinic or expanded hours or space (Y&F)
    - P-2.1: Number of additional clinics or expanded hours or space
- P-4: Expand hours including evening and/or weekend hours (Vickery)
    - P-4.1: Increased number of hours at primary care clinic over baseline
- P-5: Train/hire additional primary care providers and staff (Vickery, Garland)
    - P-5.1: Increased number of providers and staff and/or increase in number of clinics for existing providers
- P-1: Establish additional/expand existing/ relocate primary care clinics (De Haro)
    - P-1.1: Number of additional clinics or expanded hours or space

- I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services
    - I-12.1: Documentation of increased number of visits

Unique community need identification numbers the project addresses

- *CN.4 – Lack of Primary Care and Pediatric Services*

Related Category 3 Outcome Measure(s)

OD-1: Primary Care and Chronic Disease Management

- IT-1.2: Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs (Non standalone measure)
- IT-1.12: Diabetes care: Retinal eye exam (Non-standalone measure)
- IT-1.20: Other: % of patients who by age 13 years were up-to-date with recommended adolescent immunizations: MCV4 and Tdap/Td

Reasons/rationale for selecting the outcome measures

The tasks for primary care providers are many, including but not limited to – medication management for persistent mediations, appropriate preventive services for chronic disease such as retinal scanning for diabetics and preventive services for adolescents.[137] Among other chronic disease and acute care issues, this project will specifically address diabetes retinal exams, monitoring for patients on ACE inhibitors or ARBs, and preventive services for children and adolescents (patients who by age 13 years were up-to-date with recommended adolescent immunizations NQF 1407).

Annual monitoring for patients on persistent medications – ACE inhibitors/ARBs. Congestive heart failure (CHF) and diabetes are two of Parkland's most common diagnoses, resulting in a significant number of patients on chronic medications needing to be monitored to decrease risk of adverse drug events from long-term medication use or misuse of medications. Persistent use of ACE Inhibitors or ARBs warrants monitoring and follow-up by the medical home to assess for side-effects, particularly loss of kidney function, and adjust drug dosage/therapeutic decisions accordingly.[138] The costs of annual monitoring are then offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications[139].

[137] American Diabetes Association, Position statement: standards of medical care in diabetes - 2012 Diabetes Care, 2012. 35 (Supp 1): p. S11-S63.

[138] Jessup, M., et al., *2009 focused update: ACCF/AHA guidelines for the diagnosis and management of heart failure in adults: a report of the American College of Cardiology Foundation/American Heart Association Taks Force on Practice Guidelines: developed in collaboration with International Society for Heart & Lung Transplantation.* 2009. 119(14): 1977-2016.

[139] Briggs, A., et al., *Cost effectiveness of perindopril in reducing cardiovasular events in patients with stable coronary artery disease using data from the EUROPA study.* Heart, 2007. 93: p. 1081-1086.

Diabetes: Retinal Eye Exam. Diabetic retinopathy, one of the leading causes of blindness in adults, can be treated if detected and addressed in the early stages.[140]

Primary Care and Prevention: Adolescent Immunizations. National Quality Forum Endorsed Measure of adolescents 13 years of age who had recommended immunizations by their 13th birthday to include TDaP vaccine which protects against tetanus, diphtheria and pertussis[141] and Meningococcal conjugate vaccine, which prevents meningococcal disease.

Relationship to other Projects

As stated earlier, Parkland fully intends to utilize the opportunities set forth through the waiver to insure its sustainability and viability in the region as the major safety net public hospital serving Dallas County. Parkland will balance the care continuum to insure those patients who need a medical home and/or require care through a chronic care model have access and also assure that the patients who do not need a medical home but require occasional medical care also receive the care they need in the right setting. All Parkland projects address a key component of the care continuum that must be addressed to find the right balance. This balance will insure all patients get the right care at the right time in the right place. Without expanding the primary care system, Parkland would be unable to successfully balance the needs of the patients who must seek care throughout the entire health system, thus, all projects are inter-connected elements within Parkland's projects.

Projects specific to expanding primary care include the following:

Unique Project	Option	Project Description
127295703.1.1	1.1.2	Expand existing primary care capacity – Grand Prairie
127295703.1.6	1.1.2	Establish new primary care clinics – Acute Response Clinic

Category 4 related outcomes

- RD-1: Potentially Preventable Admissions for diabetes and hypertension
- RD-2: 30-day Readmissions for CHF and diabetes
- RD-5: Emergency Department
- RD-6: Optional Initial Core Set of Health Care Quality Measures for screenings
    - Annual monitoring for patients on persistent medications
    - Diabetes Care

Relationship to other Performing Providers' Projects and Plan for Learning Collaborative

[140] American Optometric Association. *Diabetes is the leading cause of blindness among most adults*. 2012 [cited 2012 October 19]; Available from: http://www.aoa.org/x6814.xml

[141] American Optometric Association. *Diabetes is the leading cause of blindness among most adults*. 2012 [cited 2012 October 19]; Available from: http://www.aoa.org/x6814.xml.

Other performing provider projects that focus on expanding primary care capacity include:

Unique Project	Performing Provider
121790303.1.1	Baylor Medical Center at Garland
121776204.1.1	Baylor Medical Center at Irving
195018001.1.1	Baylor Medical Center at Carrollton (Trinity)
139485012.1.1	Baylor University Medical Center
138910807.1.1	Children's Medical Center
138910807.1.2	Children's Medical Center
138910807.2.1	Children's Medical Center
020943901.1.3	Medical City Dallas (HCA)
020908201.1.1	Texas Health Presbyterian – Dallas
126686802.1.1	UT Southwestern Medical Center Faculty Plan
126686802.1.2	UT Southwestern Medical Center Faculty Plan

Parkland plans to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 5.75 on a 9.0 scale. Influencing factors included:

- The moderate, but important, impact this project will have on the Dallas County low income population by introducing capacity growth of 14,000 visits over five years
- Alignment with the community need for primary care capacity expansion
- Cost avoidance by providing increased opportunity for patients in this community to obtain the right care in the right place at the right time

The benefits of primary care include: prevention, early intervention, fewer preventable ER visits, fewer hospital admissions, improved outcomes, reduced mortality, increased trust and treatment compliance.[142] These benefits have been demonstrated to be associated with

[142] Robert L Phillips, Jr. and Andrew W. Bazemore; Primary Care And Why It Matters For U.S. Health System Reform; *Health Affairs*, 29, no.5 (2010):806-810

lowering costs of care from between 20 and 33 percent.[143] The following sketches the potential range of value that could be produced through the expansion of primary care as contemplated by this project. From this broad reasonableness review, this project value is demonstrated to fit below the comparative value range.

	DY2	DY3	DY4	DY5	Total
Incremental visits from baseline	0	7,000	14,000	20,000	
Estimated cumulative incremental patients (2.74 visits per patient)	0	2,550	5,100	7,300	
Estimated per capita costs[144]	$8,952.8	$9,807.5	$10,327.3	$10,874.6	
Estimated target population cost	$0	$ 25,009,125	$ 52,669,230	$ 79,384,580	$ 157,062,935
Range of Potential Cost Reductions (20-33%)[145,146]					$ 31,412,587– $ 51,830,769
Project Valuation (Cat 1 + assoc. Cat 3)					$ 25,903,018

[143] American College of Physicians. How Is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?. Philadelphia: American College of Physicians; 2008: White Paper.

[144] Sean P. Keehan, Gigi A. Cuckler, Andrea M Sisko, Andrew J. Madison, Sheila D. Smith, Joseph M. Lizonitz, John A. Posal and Christian J. Wolfe; National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands and Economic Growth Accelerates; Health Affairs, 31, no. 7 (2012): 1600-1612

[145] Mark DH, Gottlieb MS, Zellner BB, Chetty VK, Midtling JE. Medicare costs in urban areas and the supply of primary care physicians. J Fam Pract. 1996 Jul; 43(1): 33-39.

[146] Franks P, Fiscella K. Primary care physicians and specialists as personal physicians. Health care expenditures and mortality experience. J Fam Pract. 1998 Aug; 47(2):105-109.

Unique Identifier: *127295703.1.2*	***RH PPP Reference:*** *1.1.2*	***Project Components:*** *1.1.2 (a-c)*	***Title:*** *Expand Existing Primary Care Capacity*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.4* *127295703.3.5* *127295703.3.6*	*3.IT-1.2* *3.IT-1.12* *3.IT-1.20*	*- Annual monitoring for patients on medications: ACE inhibitors or ARBS - CHF & Diabetes patients* *- Diabetes care: Retinal eye exam – NQF 0055* *- Other: % patients by age 13 are up-to-date w/ recommended immunizations: MCV4 & Tdap/Td*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-2] Implement/ expand community/school-based clinic or expanded hours or space - Youth & Family (Y&F) clinics Metric 1 [P-2.1]: Number of additional clinics or expanded hours or space Goal: Move/expand capacity for school based clinics – open Wilmer Hutchins/move Spruce and NOC (add'l 34 clinic hours/week) Data Source: Documentation of completion of move/opening Milestone 1 Estimated Incentive Payment: ~~$1,311,199~~ $1,774,932 **Milestone 2** [P-4] Expand hours or primary care clinics including evening and/or weekend hours (Vickery clinic) Metric 2 [P-4.1]: Increased hours at primary care clinic over baseline Goal: Expand evening hours-Vickery Data Source: Clinic documentation Milestone 2 Estimated Incentive Payment: $1,774,932 **Milestone 3** [P-5] Train/hire additional	**Milestone 4** [P-1] Establish additional/ expand existing/ relocate primary care clinics (De Haro clinic) Metric 4 [P-1.1]: Number of add'l clinics or expanded hours or space Goal: Expand De Haro clinic 1100 square feet Data Source: Documentation Milestone 4 Estimated Incentive Payment: $ 1,815,333 **Milestone 5** [P-5] Train/hire additional primary care providers and staff and/or increase number of primary care clinics for existing providers (De Haro clinic) Metric 5 [P-5.1]:] Increased number of providers and staff and/or increase in number of clinics for existing providers Goal: Recruit 1.5 FTE at De Haro Data Source: HR Documentation Milestone 5 Estimated Incentive Payment: $ 1,815,333	**Milestone 7** [I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 7 [I-12.1]: Documentation of increased number of visits Baseline: 139,042 visits for Vickery, Garland, De Haro, Y&F Goal: 153,042 total visits for identified clinics above Data Source: Volume Statistics Report Milestone 7 Estimated Incentive Payment: $5,437,556	**Milestone 8** [I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 8 [I-12.1]: Documentation of increased number of visits Goal: 159,042 total visits for identified clinics (Vickery, Garland, De Haro, Y&F) Data Source: Volume Statistics Report Milestone 8 Estimated Incentive Payment: $4,390,573

Unique Identifier: *127295703.1.2*	***RH PPP Reference:*** *1.1.2*	***Project Components:*** *1.1.2 (a-c)*	***Title:*** *Expand Existing Primary Care Capacity*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.4* *127295703.3.5* *127295703.3.6*	*3.IT-1.2* *3.IT-1.12* *3.IT-1.20*	*- Annual monitoring for patients on medications: ACE inhibitors or ARBS - CHF & Diabetes patients* *- Diabetes care: Retinal eye exam – NQF 0055* *- Other: % patients by age 13 are up-to-date w/ recommended immunizations: MCV4 & Tdap/Td*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
primary care providers and staff (Vickery, Garland clinics) Metric 3 [P-5.1] Increased number of providers and staff and/or increase in number of clinics for existing providers Goal: Recruit 2.0 FTE at Garland clinic and 1.2 FTE at Vickery clinic Data Source: HR Documentation Milestone 3 Estimated Incentive Payment: $1,774,931	**Milestone 6** [I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 6 [I-12.1]: Documentation of increased number of visits. Baseline DY1: 139,042 visits: De Haro clinic: 53,025 Garland clinics: 50,823 Vickery clinic: 17,858 Youth & Family clinic: 17,336 Goal: 143,000 total visits for identified clinics above Data Source: Volume Statistics Report Milestone 6 Estimated Incentive Payment: $ 1,815,333		
Year 2 Estimated Milestone Bundle Amount: $5,324,795	**Year 3 Estimated Milestone Bundle Amount:** $5,445,999	**Year 4 Estimated Milestone Bundle Amount:** $5,437,556	**Year 5 Estimated Milestone Bundle Amount:** $4,390,573
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):			**$20,598,923**

Project Option 1.3.1 – Implement Chronic Disease Management Registry

Unique Project ID: 127295703.1.3

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare, and 7% Commercial Insurance.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY 2012 Volumes	Parkland Share of Dallas County Adults	
		% Market Share	Medicaid/Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Health Center	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Intervention: Parkland will design/ develop/ implement a patient registry that will provide support to providers in managing health care of those enrolled in Parkland's medical homes as well as those patients with chronic care conditions. The registry will support the implementation of an evidence-based chronic care model

Need for the Project: While Parkland has successfully implemented an Electronic Medical Record (EMR) system it is only one piece of the bigger puzzle. EMRs are designed for electronic charting for individual patient information. Their formats are generally hard-coded and are less flexible in expanding and integrating other systems whereas patient registries can integrate specific information from many systems including the EMR, clinical data systems such as lab, radiology and pharmacy systems and practice management systems such as scheduling, billing, online orders, etc. into a useful patient database. Parkland will review current market products and EPIC functionality to determine whether to buy or create a patient registry specific to the

needs of the patient population. According to the Agency for Healthcare Research and Quality, "the term 'patient registry' is generally used to distinguish registries focused on health information from other record sets, but there is no consistent definition in current use."[147]

Better management of patients with chronic conditions is high in the RHP9 region and at Parkland. Approximately 30,000 of Parkland's patient population have or are at high risk of being diabetic and patients with other conditions or comorbidities have also been identified for enrollment in a medical home and chronic care model. Implementing a registry will give providers the tools to monitor/track care of patients with specific needs. Such proactive management of patients will improve quality of care as well as decrease high cost utilization within the healthcare system.

Target Population: Parkland cares for 290,000 individual patients at any given time and approximately 120,000 of those patients are seen in the primary care clinics. Of that, approximately half will be eligible to be enrolled in a medical home and those patients who are enrolled in a medical home will be entered into the system-wide registry – initial projections include 12,000 adults and 12,000 children. Registry elements will be tailored to the medical home model of care for those patients.

A risk-stratification tool will also be incorporated into the registry tool that will segment the population into condition categories to identify those patients who will be enrolled in a chronic care model. As the registry is built, patients with Diabetes, Chronic Kidney Disease (CKD) and Congestive Heart Failure (CHF) and have specific utilization patterns will be enrolled into the chronic care registry – initial projections are estimated at approximately 13,600 - 15,000 patients. As the registry elements are built for specific target populations, patients with COPD, hypertension, pediatric asthma and special needs will be added to the registry.

Category 1 & 2 Expected Patient Benefits: Patients with specific chronic conditions will be identified and monitored through a patient registry that will enable improved care coordination through standardized care protocols, reminders, preventive measures and screenings as appropriate. Initially, the registry will be populated with patients with diabetes, CKD, CHF and will be expanded to include others as the chronic care model is set into place and is successful for the targeted population. By DY5, we anticipate 15,000 to be enrolled in the registry from the identified patient populations (those with Diabetes, CHF, CKD, etc).

Category 3 Outcomes: The goal of any chronic care model is to improve outcomes for patients with certain conditions. The number of patients who will be entered into the registry will be refined until the registry is set up appropriately and has been tested. Due to the initial focus on implementing the chronic care management model for patients with Diabetes, CHF and CKD, Parkland has targeted the following FY16 outcomes for improvement:

- IT-1.2: Annual monitoring of patients on persistent medications (ACE inhibitors/ARBs)
    - Goal is to increase the number of monitored patients on persistent medications

[147] AHRQ. Registries for Evaluating Patient Outcomes: A User's Guide.

        - Diabetes: 82.5% (2,282 patients in FY12) to 88%
        - CHF: 83.7% (605 patients in FY12) to 88%
- IT-1.12: Diabetes: Retinal eye exam
    - Goal: Increase number of diabetic COPC patients who receive from 0 to 3,000
    - Goal: Increase % of Family Medicine patients who receive eye exams from 48% (235/483 patients in FY2012) to 80% in FY2016
- IT-3.3: Diabetes 30-day Readmission Rate
    - Goal: Decrease percentage of readmissions from 9.2% (117 patients in FY12) to 8.7%

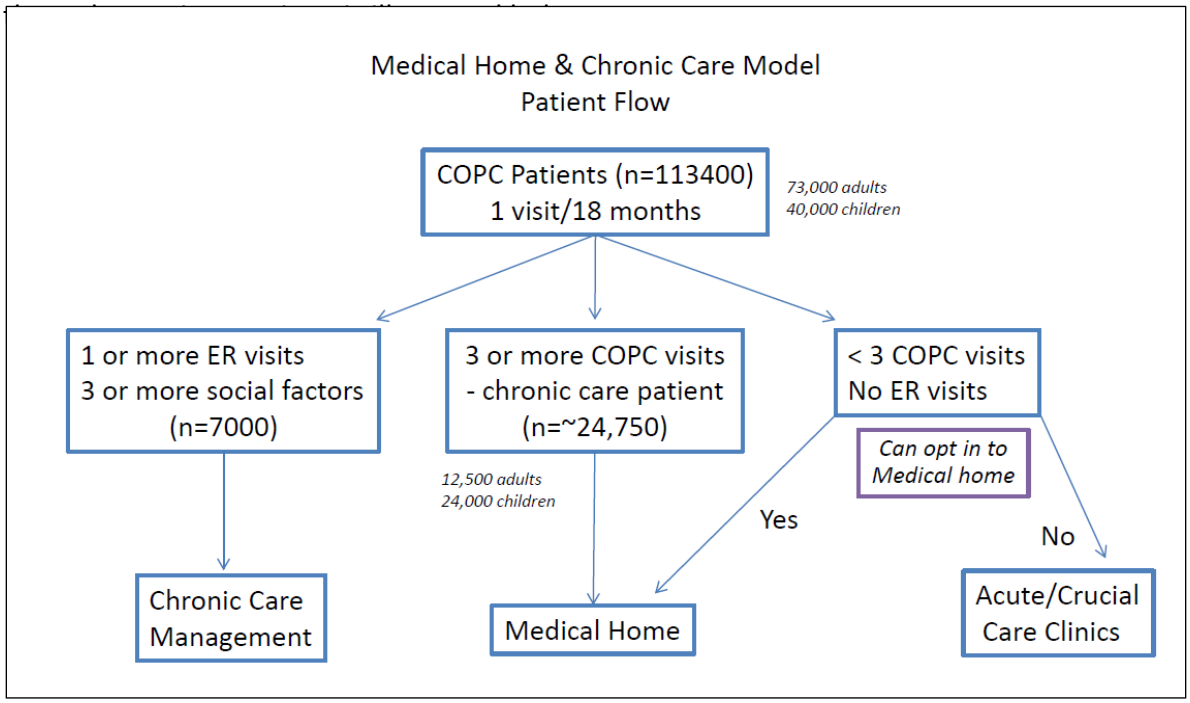
Project Description

Parkland will implement a chronic care registry for patients enrolled in a medical home and patients with targeted chronic conditions. Implementing a registry is a core component of implementation of the chronic care management model (127295703.2.4).

Based on evidence-based elements of chronic care models, a team including providers and nurses and representatives from IT, clinics administration and other stakeholders will focus on the design and implementation of a patient registry that will include registry elements specific to chronic conditions. The following steps will be taken to implement a patient registry:

1. Determine how the registry will be used and which patients will be enrolled
    a. Define targeted chronic conditions
    b. Determine stratification tools to be incorporated with the registry
    c. Determine systems to be integrated with registry (pharmacy, lab, etc.)
    d. Determine data elements required for each purpose of the registry and the current location of those data elements (other systems?)
    e. Tasks and timeline for expanding registry to other sites (specialty care, ED, etc.)

The manner in which patients will be enrolled in a medical home and chronic care model



2. Decide if the registry should be purchased, incorporated into the current EMR system (EPIC) or built. Parkland has implemented an EPIC system which has a library of pre-built registries and analytical Data Marts for prevalent chronic conditions however it is not as flexible and other available options may have the capability to be tailored in a more useful manner.

3. Determine resources required to implement registry. The costs of setting up and managing a registry can be significant and will be considered before committing to a tool. A patient registry requires ongoing collection, integration and management of data and will require resources to insure the registry is adequately supporting the implementation of medical home and chronic care models.

4. Develop an implementation plan (including objectives, tasks, accountability and time lines) that will address implications of implementing the chronic care registry system-wide (inpatient, outpatient, ambulatory, ED, etc.)

Currently, the team has identified 25,000 patients who could be enrolled into the medical home registry and of those, 15,000 with the specified chronic conditions (Diabetes, CHF, CKD, etc.) can be enrolled in the chronic condition registry.

Goals and Relationship to Regional Goals

The goal of this project is to improve care outcomes for patients with chronic conditions, such as diabetes and CHF through the use of an active tool that supports providers and patients in treating their conditions. The tool provides point of care, between care and post care information such as guideline-based intervals for assessment, testing and referrals (eg HbA1c every six months), interventions that are overdue according to clinical guidelines or text from guidelines recommending intervals for care or treatment. It provides information to build an outreach strategy to insure providers appropriately reach out to patients who may need follow up care and it provides reports that providers and their staff can use to insure patients get the right treatment at the right time in the right setting.

The goals for RHP 9 include improved access to care, improved care coordination and management and improved provider performance and outcomes. This project will support coordination of care through effective chronic care management, including the utilization of patient registries to monitor and track care for patients with specific needs.

Challenges

A major challenge in implementing a registry is determining who owns the data collection and ongoing maintenance for the registry. The registry will be utilized by primary care physicians located throughout Dallas County, specialists located in the specialty clinics onsite as well as providers in the hospital's ED and inpatient units. As an organizational strategic initiative, implementing a chronic care registry is at the top of the priority list and accountability for the registry must align with accountability for providing care through the medical home and chronic care models. The identified team is planning to submit recommendations to executive leadership.

With 40,000 inpatient visits and 1,000,000+ outpatient visits annually, another major challenge is the smooth integration of a system-wide registry such that providers across the care delivery system will be aware and utilize the system to insure all services are tracked as these patients are treated across the health system. This will require significant education for providers and staff and should be addressed in the implementation plan for the registry in recommendations to executive leadership.

Long-term, it would provide a community benefit to implement a region-wide registry; however, the challenge would be identifying those patients who need to be enrolled in the chronic care management model, especially as many who do need that treatment for chronic conditions only access care sporadically and may seek treatment at various EDs across the region. The DFWHC has a regional database that provides information on ED visits throughout the region and performing providers are able to review cases where patients are hitting various

EDs for service. This may be an opportunity for collaboration in finding regional solutions to providing chronic care management to patients.

5-Year Expected Outcome for Provider and Patients

The expected outcome will be a significant increase in the number of patients monitored through the registry. Based on the complexities of setting up a system-wide registry, piloting/testing it and then implementing it, the initial set of patients who will be enrolled in the registry will be those who are enrolled in a medical home. Additionally, those identified with diabetes, CHF and CKD will be enrolled. As the registry becomes functional, additional conditions will be targeted and patients with COPD, hypertension, pediatric asthma, etc. will be enrolled.

Starting Point/Baseline

The registry has not been built at this time so the baseline for the number of patients included in the registry is zero (0).

Rationale

While a chronic care management model can be incorporated into practice without a patient registry, the registry provides the key data repository for patient information specific to their condition.

The purpose of the registry is to[148]:

- Describe natural history of disease
- Determine clinical effectiveness or cost effectiveness of health care products/services
- Measure or monitor safety and harm
- Measure quality of care

Electronic registries can assist physicians in key processes for managing chronic disease:[149]

1) Printed patient reports used at point of care provide condition-specific information and prompt physicians/care teams to deliver recommended care/treatment

2) Registry-generated exception reports identify patients who have missed appointments, overdue for care or not meeting management goals

[148] Gliklich RE, Dreyer NA, eds. "Registries for Evaluating Patient Outcomes." (Prepared by the Outcome DEcIDE Center (Outcome Sciences, Inc. d\b\a Outcome), under Contract No. 290-05-0035-1.) AHRQ Publication No. 07-EHC001.Rockville MD: Agency for Healthcare Research and Quality

[149] NAS Consulting Services. Chronic Disease Registries: A Product Overview. California Healthcare Foundation. 2004.

3) Progress reports provide information regarding extend the care teams are doing in delivering care

4) Stratified population reports place patients in risk categories to target interventions for patients with specific needs/risks

Project Components

Required core components for Project Option 1.3.1 – Implement a chronic disease management registry include:

a) Enter patient data into unique chronic disease registry. *Providers leading this effort will identify specific patient populations/conditions that would benefit from being tracked and monitored through a registry*
b) Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need. *As the registry is being built, specific elements and report capabilities will be incorporated to assist providers in care management of identified patients*.
c) Use registry reports to develop and implement targeted QI plan. *Registry report capabilities will be built and integrated with reportable information that providers can use to improve protocols/treatments/etc.*
d) Conduct quality improvement for project using methods such as rapid cycle improvement. *Parkland will utilize registry information to target improvements in care and will share findings with other providers across health system including providers in subspecialty care clinics and the hospital care transitions team*.

Milestones and Metrics

- P-3: Develop cross-functional team to evaluate registry program
    - P-3.1: Documentation of personnel assigned to evaluate registry program
- P-1: Identify one more more target patient populations diagnosed with specific chronic diseases or with multiple chronic conditions
    - P-1.1: Documentation of patients to be entered into registry
- P-2: Review current registry capability and assess future needs
    - P-2.1: Documentation of review and assessment of future needs
- P-5: Demonstrate registry automated reporting ability to track and report patient demographics, diagnoses, patients in need of services or not at goal
    - P-5.1: Documentation of registry automated report
- P-4: Implement/expand functional disease management registry

    - P-4.1: Registry functionality is available at X% of Performing Provider sites and includes expanded number of targeted diseases/conditions
- P-12: Participate in bi-weekly interactions with other providers and RHP to promote collaborative learning around shared or similar projects
    - P-12.1: Number of bi-weekly meetings, calls, or webinars
    - P-12.2: Share Challenges and solutions
- I-15: Increase percentage of patients enrolled in registry
    - I-15.1: Percentage of patients in registry
- I-19: Spread registry functionality throughout Performing Provider facilities
    - I-19.1: Increase number of clinics/sites associated with Performing Provider's facility that are providing continuity of care for the defined population using the disease management registry functionality

Unique Community Need Identification Numbers the Project Addresses

- *CN.9 – Lack of care management resources for Chronic Disease*

How the Project represents a new initiative

Implementing a chronic care registry is a new initiative for Parkland. The registry will be in support of implementation of a chronic care model throughout the Parkland Health & Hospital System. This will not only provide opportunities for improved care outcomes for those patients but provide information to reduce unnecessary utilization of services by understanding unmet needs of those patients.
The project has no related activities funded by U.S. Department of Health & Human Services.

Related Category 3 Outcome Measure(s)

OD-1: Primary Care and Chronic Care Management

- IT-1.2: Annual monitoring of patients on persistent medications – angiotensin converting enzyme (ACE inhibitors) or angiotensin receptor blockers (ARBs)

- IT-1.12: Diabetes Care: Retinal Eye Exam

OD-3: Potentially Preventable Readmissions

- IT-3.3: Diabetes 30-Day Readmissions

Reasons/Rationale for selecting outcome measures

The outcomes for this project align with those for the chronic care management model project (127295703.2.4) for consistency purposes. Initially, the implementation of the chronic care model will focus on patients with diabetes and CHF and those with Hypertension, thus the following outcomes were chosen:

Annual Monitoring of patients on persistent medications. Hypertension and diabetes are Parkland's most common diagnoses, resulting in a significant number of patients on chronic medications who need to be monitored in order to decrease risk of adverse drug events from long-term medication use or misuse of medications. The costs of annual monitoring are then offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications[150].

Diabetes – Retinal Eye Exam. Diabetic retinopathy, one of the leading causes of blindness in adults, can be treated if detected and addressed in the early stages.[151] The registry will provide immediate tracking reports to identify those patients who have and have not received certain tests/exams as recommended. Such immediate feedback will allow immediate notifications to patients to improve compliance with treatment.

Diabetes Readmissions. According to the Texas Health & Human Services 2012 report "Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal Year 2010" , Texas Medicaid paid for 710,233 inpatients stays (24% of all inpatient stays in Texas) at a cost of $3.3 billion. In the report, the diabetes readmissions rate across the state was 7.8% in 2010 (based on 2,773 initial admissions) and the rate of readmissions increased as the level of severity increased. Readmission rates may actually be higher for public safety net hospitals due to care complexities and costs may be significant as those patients tend to be indigent. The patient registry will provide reportable information to insure providers are prompted to provide recommended treatments that should assist in reducing unnecessary utilization of services.

Relationship to Other Projects

Parkland intends to balance the care continuum to insure those patients who need a medical home and/or require care through a chronic care model have access and also assure that the patients who do not need a medical home but require occasional medical care also receive the care they need in the right setting. All Parkland projects address a key component of the care continuum that must be addressed to find the right balance. This balance will insure all patients get the right care at the right time in the right place.

This project supports the project to implement a chronic care management model. Because patients enrolled in the medical home will be in the main patient registry projects related to expanding the medical home are also related. Specifically, projects related to implementation of a chronic care registry include the following:

Unique Project	Option	Project Description
127295703.2.1	2.1.1	Expand medical home model – COPCs
127295703.2.4	2.2.1	Expand chronic care management model

[150] Briggs, A., et al., *Cost effectiveness of perindopril in reducing cardiovasular events in patients with stable coronary artery disease using data from the EUROPA study.* Heart, 2007. **93**: p. 1081-1086.
[151] American Optometric Association. *Diabetes is the leading cause of blindness among most adults*. 2012 [cited 2012 October 19]. http://www.aoa.org/x6814.xml

127295703.2.11	2.11	Expand medical home model – Family Medicine

Category 4 related outcomes

- RD-2: Potentially Preventable Readmissions for diabetes, CHF, renal disease
- RD-5: Emergency Department
- RD-6: Optional Initial Core Set of Health Care Quality Measures for screenings
    - Annual monitoring for patients on persistent medications
    - Diabetes Care

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Projects to implement a chronic care management registry or care model for patients with certain conditions include the following (Project Option 1.3 or 2.2):

Performing Provider	Unique Project	Project Option
Baylor University Medical Center	139485012.2.2	Expand Chronic Care Management Model – Diabetes (HbA1c poor control, BP control, foot exam)
Baylor Medical Center at Garland	121790303.2.2	
Baylor Medical Center at Irving	121776204.2.2	
Baylor – Carrollton (Trinity)	195018001.2.1	
Children's Medical Center	138910807.1.3	Implement pediatric chronic disease registry
Denton County Health & Human Serv	136360803.2.1	Implement disease registry – diabetes
Methodist Charlton Medical Center	126679303.2.1	Expand Chronic Care Management Model – Diabetes (30-day readmission, Hba1c, BP control)
Methodist Dallas Medical Center	135032405.2.2	
Methodist Richardson Medical Center	209345201.2.2	
Texas Health Presb Hospital Denton	020967801.2.2	Expand Chronic Care Management Model: Diabetes (HbA1c poor control, Readmissions)
Texas Health Presb Hospital Kaufman	094140302.2.2	
UT Southwestern – Faculty Practice	126686802.2.2	Expand Chronic Care Management

Parkland plans to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 7.65 on a 9.0 scale. Influencing factors included:

- Parkland serves more than 290,000 Dallas County residents annually, of which 48% are unfunded and 31% are Medicaid recipients
- The strong impact this project will have with respect to identifying, at the health system level, the patients among Parkland's vulnerable population, at highest risk for preventive and maintenance services
- Alignment with the community need for chronic disease management
- Cost avoidance by providing increased opportunity for patients in this community to obtain the right care in the right place at the right time
- Opportunities for partnership and collaboration with the many performing providers in RHP 9 that are pursuing the chronic disease management projects

This project facilitates the implementation of chronic disease models, protocols and disease-specific preventive and monitoring interventions. The value of this project is integrally related to the successful achievement of the chronic disease aspects of those projects and the value of their outcomes.

Unique Identifier: *127295703.1.3*	***Project Option:*** *1.3.1*	***Project Components:*** *1.3.1 (a-d)*	***Title:*** *Implement a Chronic Disease Management Registry*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.7* *127295703.3.8* *127295703.3.9*	*3.IT-1.2* *3.IT-1.12* *3.IT-3.3*	*- Annual monitoring of patients on persistent medications – ACE inhibitors or ARBs* *- Diabetes Care: Retinal Eye Exam* *- Diabetes 30-Day Readmissions 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 cross-functional team to evaluate registry program Metric 1 [P-3.1] Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program Goal: Establish team and schedule meetings Data Source: Team roster, team meeting minutes Milestone 1 Estimated Incentive Payment (max amount): $2,361,431 **Milestone 2** [P-1] Identify one or more target patient populations diagnosed with selected chronic disease Metric 2 [P-1.1] Documentation of patients to be entered into the registry Goal: Identify target populations and time line for incorporating into registry Data Source: Performing Provider records/ documentation	**Milestone 4** [P-5] Demonstrate registry automated reporting ability to track and report patient demographics, diagnoses, patients in need of services or not at goal and preventive care status Metric 4 [P-5.1]: Documentation of registry automated report Goal: Automated registry report Data Source: Documentation of report Milestone 4 Estimated Incentive Payment (max amount): $3,622,773 **Milestone 5** [P-4]: Implement/ expand functional disease management registry Metric 5 [P-4.1]: Registry functionality is available at X% of Performing Provider sites and includes expanded number of targeted diseases/conditions Goal: Expand registry to include identified targeted conditions Data Source: Documentation of adoption, installation, upgrade, interface, etc.	**Milestone 6** [P-12] Participate in bi-weekly interactions with other providers and RHP to promote collaborative learning around similar projects Metric 6 [P-12.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP Goal: Schedule/number of meetings Data Source: Meeting Documentation Metric 7 [P-12.2] Share Challenges and solutions Goal: Challenges/solutions shared Data Source: Documentation and Distribution of Challenges/Solutions Milestone 6 Estimated Incentive Payment (max amount): $ 3,617,156 **Milestone 7** [I-15]: Increase percentage of patients enrolled in chronic care registry Metric 8 [I-15.1]: Percentage of patients in chronic care registry	**Milestone 8** [I-15]: Increase percentage of patients enrolled in chronic care registry Metric 9 [I-15.1]: Percentage of patients in registry Goal: 15,000 enrollees in chronic condition registry (60,000 enrollees total in medical home registry) Data Source: Registry or EMR Milestone 8 Estimated Incentive Payment (max amount): $2,920,685 **Milestone 9** [I-19]: Spread registry functionality throughout Performing Provider facilities Metric 10 [I-19.1]: Increase number of clinics/sites associated with Performing Provider's facility that are providing continuity of care for defined population using disease management registry functionality Goal: All Parkland clinics will have access to registry

Unique Identifier: *127295703.1.3*	***Project Option:*** *1.3.1*	***Project Components:*** *1.3.1 (a-d)*	***Title:*** *Implement a Chronic Disease Management Registry*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.7* *127295703.3.8* *127295703.3.9*	*3.IT-1.2* *3.IT-1.12* *3.IT-3.3*	*- Annual monitoring of patients on persistent medications – ACE inhibitors or ARBs* *- Diabetes Care: Retinal Eye Exam* *- Diabetes 30-Day Readmissions 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 (max amount): $2,361,431 **<u>Milestone 3</u>** [P-2] Review current registry capability and assess future needs <u>Metric 3</u> [P-2.1]: Documentation of review of current registry capability and assessment of future needs Goal: Completed review of current capability and future needs Data Source: EMR Documentation; Registry Milestone 3 Estimated Incentive Payment (max amount): $2,361,431	Milestone 5 Estimated Incentive Payment (max amount): $3,622,774	Baseline: 0 enrollees Goal: 10,000 enrollees in chronic condition registry (37,500 enrollees total in medical home registry) Data Source: Registry or EMR Milestone 7 Estimated Incentive Payment (max amount): $ 3,617,157	Data Source: Documentation of functionality and use across system Milestone 9 Estimated Incentive Payment (max amount): $2,920,685
Year 2 Estimated Milestone Bundle Amount: $7,084,293	**Year 3 Estimate Milestone Bundle Amount:** $7,245,547	**Year 4 Estimated Milestone Bundle Amount:** $7,234,313	**Year 5 Estimated Milestone Bundle Amount:** $5,841,371
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):			**$27,405,524**

Project Option 1.10.4 –Quality Through Transformation Initiative ("QTTI")
Substantially Modified from December 31 Submission

Unique Project ID: 127295703.1.4

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare and 7% Commercial Insurance.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY2012 Volumes	Parkland Share of Dallas County Adults	
		% Market Share	Medicaid/ Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Centers	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Intervention: This project implements the Quality Through Transformation Initiative ("QTTI") which will provide the infrastructure, governance and integrated oversight for Parkland's sixteen Waiver projects and will provide leadership and consultative support for the Region's transformational projects, learning collaboratives and integrated improvement outcome achievement.

Need for the Project:

This project will assure that the dedicated focus is applied and necessary resources are assembled to achieve successful Waiver project implementation inside Parkland and to provide coordinative and consultative support for the efforts of RHP 9 as a whole.

Target Population: Generally, the target population includes all Parkland patients (290,000 unique patients annually) with specific focus on inpatients (37,000 discharges) and ED utilizers (approximately 200,000 visits per year). Specifically, this project will impact the patients targeted by each of the Parkland Waiver projects and those of the region.

Category 1 & 2 Expected Patient Benefits: The main benefit includes a significant improvement in the care delivery system for patients who seek care at Parkland. Successful implementation of the transformational initiative through the waiver will insure that the barriers to care are addressed across the health continuum and aligned with organizational strategy to improve the care delivery system. The result will include improved patient outcomes through right care, right setting, right provider.

Category 3 Outcomes: The goals include the following FY16 outcome improvements:

- IT-9.2: ED appropriate utilization
    - Reduce number of low acuity ED visit by 50%

Project Description

Parkland will implement the Quality Through Transformation Initiative ("QTTI") to provide focused governance and resourcing to promote successful completion of Parkland's Waiver projects and to support transformation achievement across the RHP 9 region.

The Quality Through Transformation Initiative ("QTTI") will create, staff, and provide technology support for a core team that will guide, monitor and support each of the Parkland Waiver projects. Because this initiative embraces each of the Waiver's evidence-based project options 1.10.1, 1.10.2, and 1.10.3, Parkland requests that the three options be consolidated into a combined evidence-based project option characterized as 1.10.4. The core components of each of the individual options will be rolled up and addressed as core components for this project option.

The QTTI project activities will include:

Needs Assessment and Plan: A review of the Parkland Waiver projects and the RHP 9 Plan to produce a requirements definition for governance and oversight, project management, range and depth of content expertise, training and educational activities, technology requirements, collaborative process support and other related duties and functions. From this review, an implementation plan will be developed which will include: governance, project management

structure and staffing, content expert staffing, technology resourcing, training and education resourcing and facilities requirements. Within the plan, specific determinations will be made for each element as to whether to leverage existing or recruit/import new resources.

QTTI Activation: The implementation plan will be expeditiously completed and the initiative will be activated providing the internal and RHP 9 functionality as defined and required.

When activated, the QTTI team will:

- Formally charter each of the Parkland Waiver projects, establish appropriate resourcing for each initiatives including role, functions and accountabilities for each project team member.
- Review and prepare detailed work plans that align with and will successfully achieve the process milestones associated with each project
- Review the metrics associated with each project and associated outcome measure. Assure data capture methodologies are established, prepare data verification / validation procedures, and assure provision of reporting methodologies and resources. Create project performance dashboards and monitors that roll up to collective performance views.
- Establish a global and project-specific communication plans and assure provision of associated communication and sharing technologies. Provide for communication feedback loops for project team members and for Parkland system employees as large to identify issues that may impact project success or have impact on existing operational functionality.
- Establish and deploy performance improvement and change management experts, prioritize resourcing, customize Parkland-standard PI tools and methodologies to the individual characteristics of each project.
- Provide education and training regarding the PI methodologies, tools and expected outcome to Parkland senior leaders and project leadership and staff members. Provide just-in-time training, coaching and course correction mapping as appropriate.
- Consult on RHP 9 plan implementation; provide leadership for performance improvement, collaborative learning and other inter-institutional activities.

While this project is characterized as an initiative, through the course of DY2 through DY5, it is intended that the QTTI will model, bridge and become institutionally hardwired – the system transformational infrastructure and framework.

Goals and Relationship to Regional Goals

This project is intended to enable successful achievement of the Parkland Waiver projects and to provide integral support the achievement of the RHP 9 plan – at the individual entity level and for the collective performance of the region.

Challenges

The size and scope of this project presents a considerable challenge to the Parkland organization. It will require the serious direction of the Parkland executive leadership team to assure that it is vigorously supported, resourced well (people, supplies, expertise, technology) and enabled to function at a cross-system level. Given the importance of the Waiver program to Parkland and the region, it is anticipated that this challenge will be fully met.

It will also be important that this initiative become institutionalized in terms of its approach, function, methodologies and transformational thrust. The governance and oversight of the Waiver projects will provide the opportunity to trial, improve and perfect the functional performance of transformational project work. Interaction with teams from other RHP 9 entities and with RHPs across the state will further infuse collaborative learning and growth.

5-Year Expected Outcome for Provider and Patients

The 5-year expected outcome is a significant improvement in the care delivery system for patients who seek care at Parkland. Successful implementation of the transformational initiative through the waiver will insure that the barriers to care are addressed across the health continuum and aligned with organizational strategy to improve the care delivery system. The result will include improved patient outcomes through right care, right setting, right provider.

Starting Point/Baseline

This project is a new initiative. There is no current office to support implementation of strategic transformational initiatives. Thus, the starting point/baseline is zero. The projects being submitted are inter-related through the care continuum and the ultimate goal for the culmination of these projects is the right care, right setting, right time and right provider. The metric by which Parkland can measure this would be ED appropriate utilization. If patients are receiving care in the appropriate setting, unnecessary ED utilization will be reduced.

Rationale

The organized effort that will be required to successfully perform the Waiver projects at Parkland and for the region, will required a dedicated function/initiative that is well resourced and supported. This project will insure that the inter-related projects meet the ultimate goal which is insuring patients receive right care, right setting, right time and right provider. The metric by which Parkland will measure this would be ED appropriate utilization. If patients are receiving care in the appropriate setting, unnecessary ED utilization will be reduced.

Quality and performance improvement requires substantial initial investments in people, technology and systems. It is anticipated that the costs will be offset by the return through efficiencies and cost savings brought on by improved care. The Agency for Healthcare Research and Quality recommends hospital systems utilize strategic management of human resources (as

the largest expense for organizations) to make strategic choices about which improvement initiatives to pursue and how best to implement these initiatives.[152]

For Parkland to be successful in transforming the care delivery system, an organizational commitment to the oversight of the waiver implementation strategy will provide the enterprise the opportunity to align all initiatives in one direction which will ultimately result in a balanced care continuum.

Project Components

For Parkland, the function is being redesigned and thus intends to meet core components of the three project options (1.10.1-1.10.3) through Project Option 4 as an "Other" project option:

Enhance improvement capacity through people (1.10.1), technology (1.10.2), systems (1.10.3):

a. Provide training to clinical and administrative staff on PI strategies, methodologies and culture. *Initial investment in recruitment of staff will be made and as new employees are recruited, they will be trained and educated regarding best evidence-based practice regarding performance improvement. This training will provided will also be extended to Waiver project teams to inform and enhance their work.*
b. Develop employee suggestion system that allows identification of issues that impact work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement. *An open, bilateral communication plan will be deployed to solicit input and feedback among Waiver project teams, across the Parkland system and across the RHP 9 Waiver performing providers and stakeholders.*
c. *(1.10.2-specific):* Design data collection systems to collect real-time data used to drive quality improvement. *Data systems will be required to collect and organize data specific to the Waiver projects and their outcome measures.*

Milestones and Metrics

- P-1: Establish PI Office to collect, analyze, manage real-time data and monitor improvement trajectory and improvement activities
    - P-1.1: Establish office
    - P-1.2: Office engaged in collecting, analyzing real-time data
    - P-1.3: QI activities
- P-6: Hire and train "QTTI" staff in proven QI principles, tools, process

[152] Agency for Heathcare Research and Quality 2012. Using Workforce Practices To Drive Quality Improvement : A Guide for Hospitals http://www.ahrq.gov/qual/workforceguide.html

    - P-6.1: Staff trained
- P-5: Enhance/expand organizational infrastructure & resources to store, analyze, share patient experience and/or quality measures data; utilize them for quality improvement
    - P-5.1: Increased collection of patient experience and/or quality measures data
- P-X.1: Insure implementation plan aligns with New Parkland transition plan so sustainable implementation will be addressed through the transition to New Parkland
    - P-X.1 New Parkland Transition Plan addresses transformational initiative and vice versa
- P-4: Participate in/present to quality/performance improvement conferences, webinars, learning sessions or other venues
    - P-4.1: Number of learning events attended and number of learning events at which a presentation was delivered summarizing the providers improvement activities and results
- I-8: Create a quality dashboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures
    - P-8.1: Submission of quality dashboard

Unique community need identification numbers the project addresses

- *CN.11 - Patient Safety and Quality*

How the project represents a significant enhancement to an existing delivery system

This project will leverage and extend current QAPI capabilities establishing and hardwiring the capabilities of the Parkland organization to tackle, successfully perform and achieve the intended outcomes of transformational projects. In addition to achieving the results of the Parkland Waiver projects and supporting the successful performance of the region, the Parkland system will have established a sustainable functional strength that will enable the organization to continue transformational improvement beyond the term of the Waiver.

Related Category 3 Outcome Measure(s)

- OD-9: Right Care, Right Setting
    - 9.2: ED appropriate utilization

Reasons/Rationale for selecting outcome measures

ED Appropriate Utilization is the main element of the Parkland care continuum. It determines the majority of admissions to the hospital as well as the referrals to the primary and specialty care clinics. A recent ED Study found that 40% of ED visits were for patients with low acuity

needs. At any given point, Parkland's ED is at 300-400 patients awaiting care. The ED has been at and over capacity causing backlogs at every point in the system. If access were available to patients at other appropriate settings such as primary care and specialty care clinics, and possibly urgent clinics, the ED congestion could be minimized providing access to those patients who truly need emergency services. This project focuses on balancing the care continuum and the ED is the scale pillar which determines the balance of patient flow. Addressing this will drive a significant opportunity to calibrate the other elements of the continuum.

Relationship to Other Projects

As stated above, Parkland intends to balance the care continuum. All Parkland projects address a key component of the care continuum that must be addressed to find the right balance. This balance will insure all patients get the right care at the right time in the right place, thus this project directly relates to each of the Parkland projects.

Category 4 Related Outcomes

- RD-5: Emergency Department

Relationship to Other Performing Providers' Projects and Learning Collaborative
This project is intended to provide RHP 9 leadership and consultation for performance improvement, collaborative learning and other inter-institutional activities. There are no other similar RHP9 projects.

Parkland will be an active leader and participant in the development and ongoing conduct of Project Learning Collaboratives appropriate to this project, as organized by RHP 9 and described in Section IV - Stakeholder Engagement. Parkland will participate in any Outcomes Learning Collaborative associated with project outcomes to obtain additional perspectives that may enable improvement of the project. The exchange of best practices and shared learning contributes to continuous quality improvement and will advance this project's success.

Project Valuation

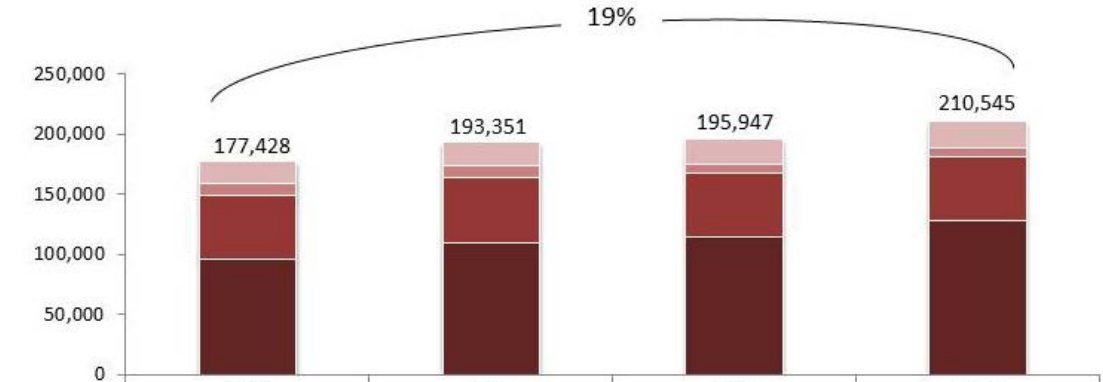
Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 8.6 on a 9.0 scale. Factors that influenced this score included:

- The transformational impact that this project will have on the Parkland system and its ability to fulfill its mandate to provide excellent and safe care the medically indigent patients in Dallas County – more than a quarter of a million served annually

- Alignment with the community need to advance patient safety and reduce harm caused to patients in the health care setting
- Alignment with RHP 9 goals of improved provider performance and outcomes
- Cost avoidance through improvements in quality and safety that reduce error, duplication and rework
- Cost avoidance through improvements in quality and safety that reduce error, duplication and rework

Specifically, this project is anticipated to directly support the achievement of the Parkland Waiver initiatives, create a hub for transformational work within the Parkland system.

The extraordinary growth in Parkland's ED volume over the four year period from 2010 to projected 2013, presented in the chart below, is a demonstration of a regional health system that is out of balance.



	2010	2011	2012	2013P
ICC	18,566	19,324	20,578	22,137
Psych ED	9,516	10,027	6,819	6,989
Urgent ED	52,418	54,337	53,357	52,667
Main ED	96,928	109,663	115,193	128,752

Successful achievement of the Parkland and the regional Waiver projects will bend the curve of patients seeking care in the most expensive setting. With a conservative estimated excess cost per ED visit of $500, a reduction of approximately 19,000 inappropriate ED visits per year over 4 years would equate to the project value assigned to this project and its associated outcome measure.

Unique Identifier: *127295703.1.4*	***RHP Reference:*** *1.10.4*	***Project Components:*** *NA*	***Title:*** *Enhance Performance Improvement and Reporting Capacity – Quality Through Transformation Initiative (QTTI)*
Performing Provider: Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.10*	*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-1] Establish PI Office to collect, analyze, manage real-time data and monitor improvement trajectory and improvement activities – QTTI Office Metric 1 [P-1.1]: Establish office Metric 2 [P-1.2]: Office engaged in collecting, analyzing real-time data Metric 3 [P-1.3]: QI activities Data Source: Documentation Milestone 1 Estimated Incentive Payment (max amount): $3,982,021 **Milestone 2** [P-6] Hire/train QTTI staff in proven QI principles, tools, process Metric 4 [P-6.1]: Staff trained Data source: HR documentation Metric 5 [P-6.2]: Analysts hired Data Source: HR documentation Milestone 2 Estimated Incentive Payment (max amount): $3,982,021	**Milestone 3** [P-5] Enhance or expand organizational infrastructure and resources to store, analyze, share patient experience and/or quality measures data, as well as utilize them for quality improvement Metric 6 [P-5.1]: Increased collection of patient experience and/or quality measures data being collected Data Source: PI documentation Milestone 3 Estimated Incentive Payment (max amount): $4,072,660 **Milestone 4** [P-X.1]: Insure implementation plan aligns with New Parkland transition plan so sustainable implementation will be addressed through the transition to New Parkland facilities Metric 7 [P-X.1] New Parkland Transition Plan addresses transformational initiative and vice versa Goal: Alignment with Transition Plan to new facilities Data Source: New Parkland Transition Plan and QTTI plan Milestone 4 Estimated Incentive Payment (max amount): $4,072,660	**Milestone 5** [P-4]: Participate in/present to quality/performance improvement conferences, webinars, learning sessions or other venues Metric 8 [P-4.1]: Number of learning events attended and number of learning events at which a presentation was delivered summarizing the providers improvement activities and results Goal: Attend learning events and share information on initiative and results Data Source: Learning events' agendas, abstracts or materials, related to provider's presentation Milestone 5 Estimated Incentive Payment (max amount): $4,066,346 **Milestone 6** [I-8]: Create a quality dashboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction	**Milestone 7** [I-8]: Create a quality dashboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures Metric 10 [I-8.2] Demonstration of how quality dashboard is used to drive rapid-cycle performance improvement Data Source: Documentation from quality improvement office Milestone 7 Estimated Incentive Payment (max amount): $6,566,770

Unique Identifier: *127295703.1.4*	***RHP Reference:*** *1.10.4*	***Project Components:*** *NA*	***Title:*** *Enhance Performance Improvement and Reporting Capacity – Quality Through Transformation Initiative (QTTI)*
Performing Provider: Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.10*	*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)**
		measures <u>Metric 9</u> [I-8.1]: Submission of quality dashboard Goal: Develop dashboard Data Source: Quality improvement data system Milestone 6 Estimated Incentive Payment (max amount): $4,066,346	
Year 2 Estimated Milestone Bundle Amount: $7,964,042	**Year 3 Estimated Milestone Bundle Amount:** $8,145,320	**Year 4 Estimated Milestone Bundle Amount:** $8,132,692	**Year 5 Estimated Milestone Bundle Amount:** $6,566,770
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):			**$30,808,824**

Project Option 1.9.2 – Expand Specialty Care Capacity

Unique Project ID: 127295703.1.5

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare and 7% Commercial Insurance.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY2012 Volumes	Parkland Share of Dallas County Adults	
		% Market Share	Medicaid/ Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Centers	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Intervention. In order to improve access to specialty care, Parkland is developing a data-driven gap analysis to determine the priority services to be expanded based on patient demand and barriers to access those services. With constrained capacity at every entry point, Parkland must balance the care continuum – as primary are access is increased specialty access must also increase to meet the demand of those patients who must be referred. Additionally, a percentage of inpatients get referrals to specialty services after discharge and as the initiatives for care transitions and patient navigation are implemented, the increased need for services must be considered.

Several clinics have already been identified for focused efforts to improve access and others will be included as appropriate. Implementation plans, including workforce plans and/or plans for recruitment of mid-levels providers, extended hours of operation, etc. will be developed to insure improved access to those services.

Need for Project. Parkland provides almost 1 million clinic visits (62% unfunded/19% Medicaid) and 200,000 ED visits (64% unfunded/22% Medicaid) annually. Currently referrals to specialty care are beyond capacity and patients experience long waits for appointments which drives many to seek care in the ED. The ED is at capacity with approximately 40% of the volume requiring a lesser level of care that could be provided in an ambulatory/outpatient care setting.

Target Population. The specialty clinics provided 345,000 visits in FY2012 and currently more than 80% of the patients seen in Parkland's ambulatory clinics are unfunded/Medicaid. Preliminary review has shown that the following specialty clinics have constrained access and will be the initial focus for this project: General Surgery/ Evaluation, Dermatology, Ophthalmology, Diabetes, GI/Liver, Cardiology, and Neurology. These clinics provided approximately 75,000 visits in FY2012 but demand is beyond capacity and many patients are on wait lists. Wait lists can be out as many as 400 days for some clinics. With improvements made through this project, projected capacity will be 91,000 visits in DY5.

Category 1 or 2 Expected Patient Benefits. This project seeks to increase specialty care access in accordance with the expansion of primary care, expanding the medical home model and the chronic care model throughout the Parkland care delivery system. This will provide not only better access but overall improved care coordination and management by providing necessary services in a more timely manner to alleviate unnecessary visits to the ED or readmissions to the hospital.

Category 3 Outcomes/Goal. Expanding specialty care should provide the following outcomes:

- IT.1.1: Improved access reported through third next available appointment. Goal is to decrease days to third next available as determined for each clinic.
    - General Surgery: 280 to 205
    - Surgery Evaluation: 280 to 205
    - Ophthalmology: 181 to 132
    - Dermatology: 211 to 162
- IT-9.2: Appropriate ED utilization. Goal is decrease inappropriate ED utilization of patients in medicine clinics (GI/Liver, Neurology, Cardiology, Diabetes) by 15% in DY5 (baseline 7,198 ED visits for patients in those clinics)

Project Description

This project will improve access to specialty care at Parkland through identification of highly demanded specialty service (gap analysis) and implementation plans to reduce barriers.

In FY2012, Parkland provided approximately 345,000 specialty clinic visits (an increase of 7% from FY2011) and although wait times for some clinics are within benchmark standards, others are not. Parkland has initially identified several specialty clinics that require a concerted effort to improve access. A data-driven gap analysis will determine other priority services based on patient demand and barriers to access those services. Implementation plans, including workforce plans, to expand services will be developed to improve access to those services.

Based on wait lists and appointment wait times, the number of requested referrals and demand from other clinics within and outside of Parkland's health system, the following medical and surgical specialty clinics have been identified for initial focus in improving access:

- Diabetes
- Cardiology
- GI/Liver
- Neurology
- Smoking Cessation
- General Surgery
- Ophthalmology
- Dermatology

The focus of this project is to implement plans to improve access in these clinics. Additionally, Parkland is focusing on prevention and a large majority of patients are smokers which is general knowledge that increases risk of cardiac, respiratory and other diseases as well as exacerbates conditions such as diabetes.

Goals and Relationship to Regional Goals

The goal of this project is to increase access to specialty care, especially for those with low incomes (<200% FPL).

Regional goals include improved access to care, care coordination and management and provider performance and outcomes. Expanding specialty services will meet the goals of improving access if the necessary resources can be obtained and will also improve care coordination and management. Many patients within Parkland's health system have learned their way around waits in certain clinics by finding other doors into the system (such as the ER) which causes backlog and inappropriate use of sites of care.

Through this project, implementation plans will be executed to insure better coordination of care to minimize patients having to find other ways to get the care they need when they need it. This will improve access in the appropriate care settings for everyone.

Challenges

One challenge for Parkland is the increasing demand for specialty care. Currently some of the specialty clinics have long waits for appointments and many patients seek care in the ED to avoid those waits, thus the ED is at capacity and the new hospital's ED will not be sufficiently expanded to meet increasing demand. Parkland is conducting a gap assessment that will direct a data-driven prioritization of the services that must be expanded and then develop a robust implementation plan with the appropriate financial projections

Another challenge is the regional physician shortage. With the physician shortage in Texas expected to increase from 30% to 50% by 2016, as identified in the Community Needs Assessment coupled with the substantial demand for care by the low income population, many seek care in the ED. This increases costs and causes capacity bottlenecks for emergencies. Parkland intends to do a comprehensive market assessment to determine specialty care needs for those who may seek care in the ED but have lower acuity needs that could be better addressed in an ambulatory care setting. Parkland is also recruiting mid-level providers to assist in providing care necessary in the specialty clinics.

Additional challenges include collecting accurate and consistent data to measure progress to goals and patient scheduling systems, policies and protocols. A team of data and clinical subject matter experts will determine the best way to quantify the next routine appointment indicator that is required for Metric 1 (I-30.1). This data must be standardized throughout the outpatient system and provided as a reportable outcome by which to measure performance.

5-Year Expected Outcome for Provider and Patients

Parkland's volume projections for outpatient care in FY2015 were approximated at 450,000 specialty clinic visits. This demand cannot be met with the current restraints (space, physician workforce, staffing, etc.), so Parkland is identifying those services that should be expanded and a time line for the expansions. The expected outcome will improve access for many patients who are waiting to get specialty care treatment. If the access to specialty care is improved, ED overutilization and readmissions will be reduced. Improving access to specialty services is one step in balancing the continuum at Parkland as more patients are directed to the appropriate setting for their care needs.

Starting Point/Baseline

In FY2012, there were 344,840 total specialty visits to the Parkland Outpatient Center on the main campus. The baseline clinic visit volumes for the identified clinics to be expanded are as follows:

Specialty Clinic	FY2012 Clinic Visits
Diabetes	4,091
Cardiology	10,488
GI/Liver	5,625
Neurology	6,813
General Surgery/Evaluation	3,219

Ophthalmology	32,574
Dermatology	12,987
Smoking Cessation	700
Total	**75,797**

Rationale

In Dallas County, few private specialist physicians accept Medicaid and indigent patients. Parkland is the main resource for specialty care and follow up for both medical and surgical subspecialties. As estimated below, the estimated demand for adult medical and surgical subspecialty care in Dallas County far exceeds the 345,000 visits currently provided.

Demand Elements	Medical Subspecialty	Surgical Subspecialty	Total
Rates of ambulatory care visits per hundred persons[153]	74.6	66.4	
Percent adult to total population in Dallas County (2011)[154]	72.2%	72.2%	
Estimated Dallas County population under 200% poverty[157]	1,063,000	1,063,000	
Estimated subspecialty visit demand	571,000	509,600	1,080,600
Parkland medical/surgical subspecialty visit volume			345,000
Subspecialty visit shortfall			735,600

As demonstrated, there is a critical shortage of subspecialty services for adults and, as a result, the emergency department often serves as the access point for needed services.

Additionally, a large percentage of Parkland patients have chronic conditions, such as diabetes and require ongoing treatment. With clinics at capacity, even if a patient can get in within a reasonable time once, their next appointment could be months out and that is not condusive to a regimented treatment schedule for patients who require ongoing care. Patients must be able to access services if clinical protocols for treating their condition are to be successful. This includes not only speicalty clinics but primary care medical homes, lab for blood draws, pharmacy, etc. For instance, some patients on specific medications must have a visit with their physician to get refills and if the physician's schedule can not accommodate, those patients will go to the ER to insure they get their medications or in unfortunate circumstances, they quit their medications which can have detrimental results. The backlog in referrals for speicalty services at PArkland thus contribute to unnecessary utilization of the ED.

Another issue has been related to scheduling and no shows. Some patients will make appointments months out and hold those appointments even if they end up not needing them

[153] Ambulatory Medical Care Utilization Estimates for 2007; US Department of Health and Human Services, Centers for Disease Control and Prevention; National Center for Health Statistics

[154] U.S. Census Bureau

any longer (just in case) – or they will forget the appointment – either way they may not show up for whatever reason. So appointment slots are held sometimes for months leaving other patients no choice but to shcedule even further out. No shows then cause negative effects on operations. This becomes a daily problem for the clinics, as well as for those patients who could have been seen had the appointment from the no show been cancelled.

With increased waits for specialty care at Parkland, more patients seek care in the ED and although Parkland's ED volumes are excessive at approximately 200,000 visits per year, the percentage of those who could be seen in a lower acuity setting is 40%. In order to alleviate the constraints on the ED and prevent other unnecessary utilization of services, Parkland is focusing efforts on expanding specialty care services that currently have long wait lists.

Project Components

Project components include the following from option 1.9.2 Improve Access to Specialty Care:

a) Increase service availability with extended hours. *The gap analysis identifies several medicine and surgical services that require extended hours of operation or additional physicians and staff. Additional clinics will be included in the project as appropriate.*
b) Increase number of specialty clinic locations. *The gap analysis identifies the services that may require additional space or locations. Facility plans for the new outpatient care building are in process* and depending on the decisions regarding facility planning the clinics that will be targeted for expansion may change and will be added to project.
c) Implement transparent, standardized referrals across system. *Improvement of the referrals system will be addressed through a team to include Patient Access Services, Information Technology and outpatient care leaders. Transition planning is also in process regarding New Parkland and operational changes that will be addressed as services are moved to the new facilities.*
d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned", opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. *Learning collaboratives with other providers within the health system including primary care providers and ancillary providers will be utilized to share findings/lessons learned in continued improvement of the care delivery system and patient flow*.

Milestones and Metrics

- P-1: Conduct specialty care gap assessment for services based on community need
    - P-1.1: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2)
- P-3: Collect baseline data for wait times, backlogs, and/or return appointments in specialties
    - P-3.1: Baseline for performance indicator
- P-12: Implement a specialty care access plan to include such components as statement of problem, background and methods, findings, implication of findings in short and long-term conclusions
    - P-12.1: Documentation of specialty care access plan
- P-X: Recruit mid-levels, providers and supporting staff for specified clinics
    - P-X1: Recruitment of identified staff per clinic
- I-23: Increase specialty care clinic visit volume; evidence of improved access for patients
    - I-23.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2)
    - I-23.2: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline DY2)

Unique Community Need Identification Numbers the Project Addresses

- *CN.8: Specialty Care*. Demand for specialty care services exceeds the current supply

How the Project significantly enhances an existing delivery system reform initiative

While Parkland has expanded some specific services in the specialty care clinics, this project provides the opportunity to perform a global assessment and gap analysis to develop a more comprehensive and focused strategy in addressing the specialty care capacity issues.

The project has no related activities funded by U.S. Department of Health & Human Services.

Related Category 3 Outcome Measure(s)

OD-1: Primary Care and Chronic Disease Management

- IT-1.1: Third next available appointment (Non-standalone Measure)

OD-9: Right Care Right Setting

- IT-9.2: ED Appropriate Utilization

Data driven reports that identify third next available appointment wait times is one method to show that expansion of services has been effective. While Third Next Available appointment is not a "good" measure for Parkland's system, it is the industry standard and one which Parkland

is attempting to define for its specialty services. It will provide some measure by which to determine success of initiatives to increase access to care. Another method to determine that is use of the ED for low acuity services. A recent report of ED utilization at Parkland showed 40% of ED visits were low acuity and could have been treated in an ambuluatory setting. If specialty access is improved, ED utilization for low acuity care should be reduced.

Both outcomes can be reported to measure Parkland's performance, which aligns with the regional goal to improve provider performance and outcomes.

Relationship to Other Projects

Parkland intends to balance the care continuum to insure those patients who need a medical home and/or require care through a chronic care model have access and also assure that the patients who do not need a medical home but require occasional medical care also receive the care they need in the right setting. All Parkland projects address a key component of the care continuum that must be addressed to find the right balance. This balance will insure all patients get the right care at the right time in the right place. Increasing specialty care is an integral component in the care continuum and constrained access increases unnecessary utilization of other services in the continuum (ED, inpatient, etc.)

Projects related to increasing access throughout the care delivery nclude:

Unique Project	Option	Project Description
127295703.1.1	1.1.2	Expand current primary care capacity – Grand Prairie
127295703.1.2	1.1.2	Expand current primary care capacity
127295703.1.6	1.1.1	Establish more primary care clinics – Acute Response Clinic

Related Category 4 measures

- RD-2: Potentially Preventable Readmissions
- RD-5: Emergency Department
- RD-6: Optional Domain: Initial Core Set of Health Care Quality Measures

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Related projects (Project Option 1.9) from RHP 9 performing providers include the following:

Performing Provider	Unique Project
Baylor Medical Center at Carrollton	195018001.1.2
Baylor Medical Center at Garland	121790303.1.2
Baylor Medical Center at Irving	121776204.1.2
Baylor University Medical Center	139485012.1.2
UTSW – Faculty Practice Plan	126686802.1.5
UTSW – Faculty Practice Plan	126686802.1.11
UTSW – University Hospital	175287501.1.1

Parkland plans to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration.

This project had a weighted average score of 8.05 on a 9.00 scale. Factors that influenced this score included:

- The large impact this project will have on when aligned with the primary care expansions required to meet demand
- Alignment with the community need for specialty care capacity expansion
- Cost avoidance by providing increased opportunity for patients in this community to obtain the right care in the right place at the right time (avoid unnecessary ED visits and admissions, readmissions)

As discussed earlier, the significant capacity shortages for adult subspecialty services create a critical need in Dallas County. This project provides incremental capacity to mitigate this significant need.

Unique Identifier: *127295703.1.5*	***Project Option:*** *1.9.2*	***Project Components:*** *1.9.2 (a-d)*	***Title:*** *Expand Specialty Care Capacity*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures :	*127295703.3.13* *127295703.3.14*	*3.IT-1.1* *3.IT-9.2*	*-Third Next Available Appointment* *-ED Appropriate Utilization*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Conduct specialty care gap assessment based on community need Metric 1 [P-1.1]: Documentation of gap assessment. Demonstrate improvement over prior reporting period Goal: Gap assessment Data Source: Needs assessment documentation Milestone 1 Estimated Incentive Payment (max amount): $3,009,667 **Milestone 2** [P-3] Collect baseline data for wait times, backlogs, and/or return appointments in specialties Metric 2 [P-3.1]: Baseline for performance indicators Data Source: Report Milestone 2 Estimated Incentive Payment (max amount): $3,009,667	**Milestone 3** [P-12] Implement specialty care access plan to include such components as statement of problem, background and methods, findings, implication of findings in short and long-term conclusions Metric 3 [P-12.1]: Documentation of specialty care access plan Goal: Specialty care access plan Data Source: Plan documentation Milestone 3 Estimated Incentive Payment (max amount): $,2,052,115 **Milestone 4** [P-X] Recruit mid-levels, providers and supporting staff for specified clinics Metric 4 [P-X1]: Recruitment of identified staff per clinic including Diabetes, Cardiology, Neurology, etc. Goal*: 4-5 mid-levels; 1-2 providers; appropriate number of support staff Data Source: HR Documentation Milestone 3 Estimated Incentive Payment (max amount): $2,052,116	**Milestone 6** [I-23] Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 6 [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline Visit Volumes (76,497): Diabetes: 4,091 Cardiology: 10,488 GI/Liver: 5,625 Neurology: 6,813 Smoking Cessation: 700 General Surgery: 3,219 Ophthalmology: 32,574 Dermatology: 12,987 Goal: Increase volumes as follows (89,089 total visits): *Diabetes: 6,606 *Cardiology: 14,423 GI/Liver: 5,968 *Neurology: 9,494 Smoking Cessation: 850 General Surgery: 3,414 Ophthalmology: 34,557	**Milestone 7** [I-23] Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 7 [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period Goal: Increase volumes as follows (91,887 total visits): *Diabetes: 6,804 *Cardiology: 14,855 GI/Liver: 6,147 *Neurology: 9,779 Smoking Cessation: 1,000 General Surgery: 3,517 Ophthalmology: 35,594 Dermatology: 14,191 Data Source: Internal reports Milestone 7 Estimated Incentive Payment (max amount): $4,963,256

Unique Identifier: *127295703.1.5*	***Project Option:*** *1.9.2*	***Project Components:*** *1.9.2 (a-d)*	***Title:*** *Expand Specialty Care Capacity*	
Parkland Health & Hospital System				*127295703*
Related Category 3 Outcome Measures :	*127295703.3.13* *127295703.3.14*	*3.IT-1.1* *3.IT-9.2*	*-Third Next Available Appointment* *-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)**
	<u>Milestone 5</u> [P-11] Launch/expand specialty care clinic <u>Metric 5</u> [P-11.1] Establish/expand specialty care clinics Goal: Increase number of patients Data Source: Documentation of new/expanded specialty care clinic Milestone 5 Estimated Incentive Payment (max amount): $2,052,116	Dermatology: 13,777 Data Source: Internal reports Milestone 6 Estimated Incentive Payment (max amount): $6,146,802	
Year 2 Estimated Milestone Bundle Amount: $6,019,334	**Year 3 Estimated Milestone Bundle Amount:** $6,156,347	**Year 4 Estimated Milestone Bundle Amount:** $6,146,802	**Year 5 Estimated Milestone Bundle Amount:** $4,963,256
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):*			**$23,285,739**

Project Option 1.1.1 – Establish more Primary Care Clinics – Acute Response Care Clinic(s)

Unique Project ID: 127295703.1.6

Performing Provider Name/TPI: Parkland Health & Hospital System/TPI 127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare and 7% Commercial Insurance.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY2012 Volumes	Parkland Share of Dallas County Adults	
		% Total Adult	Medicaid/ Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Centers	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Parkland directly employs approximately 150 primary care physicians (pediatrics, family medicine, internal medicine) who provide services in the community health centers. Campus based physician services are provided mainly by UT Southwestern Medical Center faculty under a services contract.

Intervention: Establish one or more new clinics to provide post-acute referral primary care to Parkland system patients who require post-discharge follow-up from inpatient, emergency or other episode of care but are not been established with a primary care provider or cannot secure timely primary care follow up.

Need for the Project: With an inadequate supply of primary care capacity available to individuals living at or below 200% of poverty, patients requiring primary care follow up from

acute or episodic conditions are unable to obtain timely care in the most appropriate setting. Parkland estimates indicate that the demand originating in the Inpatient and ED for such services could be at or greater than 50,000 annual visits.

Target Population: Parkland cares for more than 290,000 unique patients annually, of which 80% are indigent/Medicaid. This project will target Parkland system patients who require acute or episode-related primary care follow up care and who do not have a regular source of primary care or unable to secure a timely appointment with their regular source of primary care.

Category 1 & 2 Expected Patient Benefits: Parkland will create additional primary care access that will provide follow up care for patients discharged from the inpatient, emergency department, or other setting. The patient will obtain the right care at the right time in the right setting which will facilitate resolving the acute or episode-related condition. When concluding care in this setting and as appropriate, patients at high risk for recurrence or having unrelated health risks and who would benefit from continuous management will be risk stratified and referred, as appropriate, to Parkland or other community-based medical home settings.

Improved access to services through the acute response care clinics will trend as follows:

Volume	DY1	DY2	DY3	DY4	DY5
Baseline (FY 10.31.11)	0				
Total Clinic Visits	0	0	0	20,000	40,000

Category 3 Outcome: While the clinic will provide additional capacity of approximately 40,000 by DY5, the targeted outcome for FY2016 for this project has been identified as follows:

- IT-3.1: All Cause 30-day Readmission Rate – NQF 1789.
    - Goal is to decrease from 8.74% (2,770 patients in FY12) to 8.5%

Project Description

Establish one or more post-acute referral primary care clinics to provide primary care follow up from an acute or episodic condition to Parkland system patients who do not have a regular source of primary care or cannot secure a timely appointment from their regular source of primary care.

This project seeks to establish a coordinated solution to two related problems that affect both the Parkland health system and the patients it serves.

Problem 1 – There is a need to establish reliable access to post-discharge primary care follow up services for hospital inpatients which would contribute to reductions in hospital readmissions and/or returns to the emergency room. Evidence clearly demonstrates that inpatient readmissions within 30 days are frequent, preventable and costly. Further evidence

demonstrates that approximately 2% of all emergency department visits were made by persons discharged from inpatient care within the last 7 days.[155]

Problem 2 – There is a need to establish post-discharge primary care follow up appointments for emergency department patients which would contribute to reductions in post emergency department discharge returns to the ED. Of the 110 million annual ED visits in the United States, approximately 45% of patients are referred for outpatient follow-up ensuring treatment continuation. Appointments made at discharge from the ED have a significantly greater probability of follow-up compliance compared with patients given standard discharge instructions.[156]

This project proposes to introduce a new primary care resource that will provide a reliable supply of primary care follow up resources to patients being transitioned through the inpatient and emergency discharge processes – the targeted patients would be those for whom primary care follow up is appropriate and for whom there is no existing primary care resource or for whom that primary care resource does not have timely availability. Using broad indicators, these patients may appropriately require 50,000 primary care acute follow up visits annually.

Patients seen in this post-acute referral primary care clinic who have chronic disease conditions, are at risk for ongoing complications, or for whom a continuous primary care relationship would be valuable will be referred to a Parkland clinic or other community medical home setting, as available.

Goals and Relationship to Regional Goals

This project aligns directly to address the primary care capacity need identified in the Community Needs Assessment and specifically provides new primary care capacity to continue patient care management for patients who have presented with acute or episodic conditions requiring follow up. Adjunctively, this project will leverage the effectiveness of improved care coordination resources and facilitate standardized care transitions from inpatient and emergency settings.

Challenges

As stated in the Community Needs Assessment, the State and region in which RHP 9 resides has significant shortages of primary care physicians. When considered in the context of other primary care expansion projects, this endeavor will further strain Parkland's ability to recruit the provider and allied clinical staff required to implement this project. However, Parkland has a well-established recruitment process and pipeline that should alleviate those challenges.

[155] Emergency Department Visits by Persons Recently Discharged from U.S. Hospitals, National Health Statistics Reports, Number 6, July 24, 2008.

[156] Factors Affecting Outpatient Follow-Up Compliance of Emergency Department Patients, Journal of General Internal Medicine, 2005; 20:938-942.

5-Year Expected Outcome for Providers and Patients

This project will provide a significant and valuable new primary care resource to Parkland and the patients it serves. By DY5, it is estimated that the clinic(s) will be providing 50,000 or more new primary referral follow up visits. With additional new capacity, this project will contribute to reductions in all cause readmissions and returns to the Emergency Department.

Starting Point/Baseline

As a new primary care intervention specifically targeting post-acute discharge patients requiring primary care follow up, the baseline for visit volume is zero.

The baseline performance with respect to the percent of targeted discharge patients obtaining primary care follow up appointments will be developed in DY2.

Rationale

Primary care follow-up after acute care (inpatient or emergency) ensures proper treatment continuation of the initial condition; identifies misdiagnoses, treatment failures and complications; and supports patient compliance with the therapeutic plan. In a University of Michigan Health System study, the researchers found that only 22 percent of patients understood their diagnosis, the emergency care that was given, their post-ER care needs and what kinds of symptom would require immediate care.[157] Timely primary care follow up can mitigate understanding shortfalls and provide greater likelihood of a successful completion of a therapeutic plan.

In the current state, the Parkland system includes a 725-bed adult safety-net hospital that operates at or close to capacity throughout the year. It provides the largest emergency service in the region providing approximately 200,000 visits annually. With annual growth rates ranging from 6 to 13% over the last five years, the emergency service is operating at or above maximum capacity. Additionally, Parkland's community health clinic system also operates at functional capacity providing approximately 420,000 visits per year. In its current state, the referral flow between and among the inpatient, emergency and primary care system is at functional gridlock.

For patients being discharged in fiscal 2012, primary care referral orders were as follows: inpatient – 13,146 and emergency service – 27,072. While further study will be required to determine how many appointments were established and completed, it is well known within the Parkland system that is it very difficult to arrange for follow up primary care within the system. For the Parkland system, to have a primary care resource specifically positioned to provide post-acute primary care transitioning will be of invaluable importance to alleviating appointment gridlock and assuring timely follow up services to the patients who would have no other resource available.

[157] Annals of Emergency Medicine, doi: 10.1016/j.annemergmed.2008.05.016

How this project is a significant enhancement

This project provides a significant increase in primary care resources available to the Parkland system and the patients it serves. This project also serves as a lynch-pin to the success of three other Parkland projects. This project will provide dedicated post-acute primary care resources to alleviate demand pressure on the community health system enabling it to advance its aim to enhance the medical home model. And this project provides the resources that are necessary to support intensive care transitions investments and to leverage the investments being made in the care management arena. (These projects are outlined below.)

The project has no related activities funded by U.S. Department of Health & Human Services.

Project components

There are no required core components for Project Option 1.1.1

Milestones and Metrics

- P-X: Prepare a comprehensive plan for development of the Acute Response Clinic
    - P-X.1: Comprehensive business plan*. It will be important to study the size and the nature of the demand for services and determine which and how many geographic locations are best suited to match supply with the service demands. The model of primary care to be provided will need to be determined. Literature suggests that post hospital discharge follow up care may be best provided by the hospitalist service, but there is little evidence that this model has been used in conjunction with post emergency service care. Accordingly, it will be important to fully vet models of primary care that will yield the most productive result. The comprehensive business plan will detail the specific targets and measures that the project is intended to fulfill. This will provide the basis for performance improvement monitoring and course correcting activities. Upon completion and approval of the comprehensive business plan, facility lease space, an architect/space planner and contractor will be secured. While this project will require limited capital investment to build out the leased space, the capital investment is not contemplated to be a part of this project.*
- P-X: Determine the baseline metrics
    - P-X.1: *Define the target populations, and obtain historic metrics for primary care referrals, appointments established and completed appointments*
- P-5 Train/hire additional primary care provider and staff and/or increase the number of primary care clinics for existing providers

- P-5.1: Documentation of increase number of providers and staff and/or clinic sites. *While the facility space is being prepared for operation, Parkland will recruit and train the facility staff. During this time, the practice referral protocols and practice model will be refined. It is contemplated that by the middle to end of DY3, the new primary care clinic(s) will be readied to open.*

- P-1 Establish additional primary care clinics
    - P-1.1: Number of additional clinic(s) / scheduling slots. *Documentation will be provided of the number and location of Acute Response Clinic(s) added*

- I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services
    - P-12.1: Documentation of increased number of visits. *In DY4 the clinic(s) will be open and begin receiving referral appointments from the inpatient and emergency department care coordinators. This post-acute referral primary care clinic will begin to risk stratify and identify patients to the community clinics as appropriate for management in a medical home setting. During this year, performance relative to the visit volume targets and the percent of target population obtaining follow-up appointment access will be monitored. Progress barriers will be identified and addressed applying performance improvement methodologies.*

Unique community need identification numbers the project addresses

- *CN.4 - Primary Care and Pediatrics*. The RHP 9 Community Needs Assessment clearly identifies access to primary and preventive care as a significant need in Dallas, Denton and Kaufman counties. Expanding primary care access will also hopefully reduce unnecessary ED visits freeing capacity in the ED for more urgent needs.

- *CN.12 - Emergency Department Usage and Readmissions*. By supplying additional capacity targeted to post discharge inpatient and emergency follow up primary care, there should be an impact on reducing emergency department usage and readmissions.

Related Category 3 Outcome Measure(s)

OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates

- IT-3.1: All cause 30 day readmission rate – NQF 1789 (Standalone Measure)

Reasons/rationale for selecting the outcome measures:

This project focus is on providing follow up after acute care (inpatient or emergency) to ensure proper treatment continuation of the initial condition; identifies misdiagnoses, treatment failures and complications; and supports patient compliance with the therapeutic plan. This intervention is intended to reduce readmission to the inpatient setting.

Category 4 Related Outcomes

- RD-2: Potentially Preventable Readmissions for All Cause
- RD-5: Emergency Department
- RD-6: Optional Domain: Initial Core Set of Health Care Quality Measures

Relationship to other Projects

Parkland will balance the care continuum to insure those patients who need a medical home and/or require care through a chronic care model have access and also assure that the patients who do not need a medical home but require occasional medical care also receive the care they need in the right setting. All Parkland projects address a key component of the care continuum that must be addressed to find the right balance. This balance will insure all patients get the right care at the right time in the right place.

This project will also produce the primary care resources that will be required to support Parkland project which is designed to provide the intensive intervention that has been demonstrated to improve primary care follow up compliance for uninsured emergency department patients.[158] Related projects include:

Unique Project	Project Description
127295703.2.9	Implement/Expand Care Transitions Program
127295703.2.1	Enhance the Medical Home
127295703.2.10	Enhance Medical Home Model – Family Medicine.

Relationship to other Performing Providers' Projects and Plan for Learning Collaborative

Other performing provider projects that focus on expanding primary care capacity include:

Unique Project	Performing Provider
121790303.1.1	Baylor Medical Center at Garland
121776204.1.1	Baylor Medical Center at Irving
195018001.1.1	Baylor Medical Center at Carrollton (Trinity)
139485012.1.1	Baylor University Medical Center
138910807.1.1	Children's Medical Center
138910807.1.2	Children's Medical Center

[158] Intensive Intervention Improves Primary Care Follow-Up for Uninsured Emergency Department Patients, Academic Emergency Medicine 2005; 12:647-652

138910807.2.1	Children's Medical Center
020943901.1.3	Medical City Dallas (HCA)
020908201.1.1	Texas Health Presbyterian – Dallas
126686802.1.1	UT Southwestern Medical Center Faculty Plan
126686802.1.2	UT Southwestern Medical Center Faculty Plan

Parkland plans to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Parkland adopted the RHP 9 global method to project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 8.10 on a 9.0 scale. Influencing factors included:

- The large impact this project will have on the Grand Prairie low income population by introducing capacity growth of 40,000 visits over the five years of the project to this under-resourced community
- Alignment with the community need for primary care capacity expansion
- Cost avoidance by providing increased opportunity for patients in this community to obtain the right care in the right place at the right time

The following sketches the potential range of value that could be produced through the expansion of primary care as contemplated by this project. From this broad reasonableness review, this project value is demonstrated to fit below the comparative value range.

	DY2	DY3	DY4	DY5	Total
Potential Value of Avoiding Primary Care Clinic Crowd-Out					
Incremental cumulative visits that would have otherwise "crowded out" routine primary care clinic visit	0	0	20,000	40,000	
Ave. cumulative patients impacted	0	0	7,273	14,545	

Estimated per capita costs[159]	$8,952.8	$9,807.5	$10,327.3	$10,874.6	
Estimated target population cost	$0	$0	$ 75,110,453	$ 158,171,057	$ 233,281,510
Range of Potential Cost Reductions (20-33%)[160,161]					$ 46,656,302– $ 76,982,898
Project Valuation (Cat 1 + assoc Cat 3)					$ 36,939,956

[159] Sean P. Keehan, Gigi A. Cuckler, Andrea M Sisko, Andrew J. Madison, Sheila D. Smith, Joseph M. Lizonitz, John A. Posal and Christian J. Wolfe; National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands and Economic Growth Accelerates; Health Affairs, 31, no. 7 (2012): 1600-1612

[160] Mark DH, Gottlieb MS, Zellner BB, Chetty VK, Midtling JE. Medicare costs in urban areas and the supply of primary care physicians. J Fam Pract. 1996 Jul; 43(1): 33-39.

[161] Franks P, Fiscella K. Primary care physicians and specialists as personal physicians. Health care expenditures and mortality experience. J Fam Pract. 1998 Aug; 47(2):105-109.

Unique Project: *127295703.1.6*	***Project Option:*** *1.1.1*	***Project Components:*** *NA*	**Title:** Establish More Primary Care Clinics - Post-Acute Referral Primary Care Clinic(s)
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.38*	*3.IT-3.1*	*All cause 30 day readmissions rate NQF 1789 (Stand Alone 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] Prepare a comprehensive plan for development of the post-acute discharge referral primary care clinic(s) Metric 1 [P-X.1]: Comprehensive business plan documenting: - Service demand - Clinic site(s) - Practice model - Staffing plan - Facility(ies) development plan - Implementation staging plan - Performance improvement monitoring plan Goal: Completed business plan Data Source: Business plan Milestone 1 Estimated Incentive Payment: $ 3,796,811 **Milestone 2** [P-X] Determine the baseline metrics to be used for effectiveness assessment in DY5 Metric 2 [P-X.2]: Establish criteria defining target population, patients who obtained timely clinic	**Milestone 3** [P-5] Train/hire additional primary care providers and staff and/or increase number of primary care clinics for existing providers Metric 3 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites Goal: Add one new clinic site Data Source: Report, policy, contact Milestone 3 Estimated Incentive Payment: $3,883,234 **Milestone 4** [P-1] Establish additional primary care clinic(s) Metric 4 [I-1.1]: Number of additional clinic(s) / scheduling slots Baseline: 0 visits Goal: Establish clinic schedule Date Source: New clinic primary care schedule Milestone 4 Estimated Incentive Payment: $3,883,234	**Milestone 5** [I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 5 [I-12.1]: Documentation of increased number of visits Baseline: 0 visits Goal: 20,000 annual visits Data Source: Departmental Statistics Report Milestone 5 Estimated Incentive Payment: $7,754,427	**Milestone 6** [I-12] Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 6 [I-12.1]: Documentation of increased number of visits Baseline: 20,000 visits (DY4) Goal DY5: 40,000 visits Data Source: Departmental Statistics Report Milestone 6 Estimated Incentive Payment: $6,261,339

Unique Project: *127295703.1.6*	***Project Option:*** *1.1.1*	***Project Components:*** *NA*	**Title:** Establish More Primary Care Clinics - Post-Acute Referral Primary Care Clinic(s)
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.38*	*3.IT-3.1*	*All cause 30 day readmissions rate NQF 1789 (Stand Alone 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)**
appointments and patients who completed their appointments Goal: Criteria established Data Source: EPIC custom report Metrics include: - % target population who received a timely appointment at discharge - % appointed patients who complete their appointment Milestone 2 Estimated Incentive Payment: $ 3,796,810			
Year 2 Estimated Milestone Bundle Amount: $7,593,621	**Year 3 Estimated Milestone Bundle Amount:** $7,766,468	**Year 4 Estimated Milestone Bundle Amount:** $7,754,427	**Year 5 Estimated Milestone Bundle Amount:** $6,261,339
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):*			**$29,375,855**

Project Option 1.4.7 – Implement Health Literate Care Model and Enhance Interpretation Services and Culturally Competent Care

Unique Project ID: 127295703.1.7

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare, and 7% Commercial Insurance.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY 2012 Volumes	Parkland Share of Dallas County Adults	
		% Market Share	Medicaid/Self-Pay/ Charity
Discharges - Adult - Neonatal	37,515 36,389 1,126	 17% 27%	 42% 39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits - Community Health Center - Women's Center - Subspecialty	1,031,311 446,646 239,825 344,840	n/a	n/a

Intervention.

Parkland will implement an evidence-based 'Health Literate Care Model' which incorporates health literacy strategies into the Care Model to better engage patients in their care. Several steps will be taken to implement this model:

1) Improvements and possible consolidation of appropriate interpretation services across the health system in order to better redistribute interpretation services to meet the needs of all the sites of care

The improvements will allow for the following elements to be addressed:[162]

- Care provided with a better understanding/respect for cultural values
- Recruitment, retention, and training of staff members who reflect and respond to the values and demographics of the communities served
- Consistent administrative, management, clinical and organizational processes and policies/procedures

2) Improved training/education requirements for all interpreters at Parkland regardless of assigned site of care

3) Health literacy guidelines and interventions provided by the Agency for Healthcare Research and Quality (AHRQ) Health Literacy Universal Precautions Toolkit will be implemented and incorporated into the Chronic Care Model through the Chronic Care Model and Chronic Care Registry projects. The tool addresses all elements of the Care Model including self-management delivery system design, decision support, clinical information systems and community partners.[163]

Need for the Project: As addressed in the Affordable Care Act, health literacy is the foundation to engaging patients in their health and improving health outcomes. Parkland's inpatient survey results for the HCAHPS questions related to explanations of care/treatment by nurses and physicians provided the following results (unadjusted results for the quarter of November 2012 through January 2013):

1) Nurses explain things in a way you can understand: 8.7% stated "never" or "sometimes" while 22.2% stated "usually" and 69.1% stated "always

2) Physicians explain things in a way you can understand: 5.9% stated "never" or "sometimes" while 17.6% stated "usually" and 76.5% stated "always"

From the results above, 30% of Parkland's patients do not "always" feel they understand the explanations of their caregivers and that means a significant number of patients may be missing very critical information regarding their health and recovery.

In addition, Parkland's patient population is very diverse with almost half who do not speak English or are very limited in their English proficiency. Parkland's patient population includes more than 53% Hispanic patients, of whom 39% state their primary language is Spanish. The Hispanic and other non-speaking English patient population at Parkland contribute to the need

[162] Health Resources and Services Administration. "Cultural Competence Works." US Department of Health and Human Services. 2000.

[163] Koh, Howard, et al. "A Proposed 'Health Literate Care Model' Would Constitute A Systems Approach to Improving Patient Engagement in Care." Health Affairs 32 (2). February 2013: 357-367

for 32,000+ encounters for interpretation services per month, topping out at almost 400,000 interpretation encounters per year at Parkland.

Target Population: Specific to this project, the target population includes all Parkland patients who require interpretation assistance/services. As stated above, of Parkland's Hispanic patient population (53% of total population), 39% state their primary language is Spanish and in one month, interpretation services at Parkland have more than 32,000 interpretation encounters including in-person encounters, language line calls and Texas Interpreting Service (ASL).

Category 1 & 2 Expected Patient Benefits: Expected benefits from implementing a Health Literate Care Model at Parkland include improved communication between the provider and patient such that the treatment plan is better understood, improving compliance and also improving outcomes for patients. Additionally, as this project will affect other projects through integration of the Health Literate Care Model into the Chronic Care Model, health literacy for those patients with chronic conditions will be improved, thus reducing waste through over utilized services (ED, etc.) throughout the health system and expanding capacity in the system for other patients.

Category 3 Outcomes/Goal. The following are identified for FY2016 outcomes:

- IT-6.1: 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. Establish that patients are receiving improved communication with their physicians (and nurses) based on related HCAHPS survey questions (Standalone Measure):
    - Nurses "always" explain in the way you can understand: 85%
    - Physicians "always" explain in the way you can understand: 90%

Project Description

Parkland will implement a Health Literate Care Model across the health system that will include expanding and enhancing interpretation services for the growing number of patients who require such services.

The Health Literate Care Model is defined by incorporating health literacy strategies and tools into the accepted Care Model (formally known as the Chronic Care Model).[164] The model is

[164] Koh, H., et al. "A Propose 'Health Literate Care Model' Would Constitute a Systems Approach to Improving Patients' Engagement in Care. Health Affairs 32 (2). February 2013.

based on "health literacy universal precautions", which is to say that providers approach every patient as if they are at risk of not understanding information relative to their care or treatment. Interventions of the Health Literate Care Model are identified in the 2010 Health Literacy Universal Precautions Toolkit, developed by the Agency for Healthcare Research and Quality (AHRQ).

Implementing the Health Literate Care Model will include the following steps:

1) Parkland will improve the current interpretation services program at Parkland. This may include consolidation of interpretation services staff across the system, recruitment of an appropriate number of interpreters (based on national benchmarks) and investment in new or improved technologies to meet current demand for interpretation services. Policies and procedures will be assessed to insure they meet national and state guidelines and current training/education will be assessed to insure a more robust and appropriately skilled labor force.

2) Training/education competencies will be defined across the health system and built into requirements for interpretation services.

3) Health literacy guidelines and interventions provided by the Agency for Healthcare Research and Quality (AHRQ) Health Literacy Universal Precautions Toolkit will be implemented and incorporated into the Chronic Care Model through the Chronic Care Model and Chronic Care Registry projects. The tool addresses all elements of the Care Model including self-management, delivery system design, decision support, clinical information systems and community partners.[165]

Goals and Relationship to Regional Goals

Parkland's main goal is to decrease health disparities and improve health literacy of all patients at Parkland, and especially those LEP patients whose primary language is not English in order to improve the patient's health status. This will be done through improving interpretation services and incorporating a Health Literate Care Model into the chronic care model and other program improvements for Care Transitions and Patient Navigation.

Regional goals include improved access to care, care coordination and management and provider performance and outcomes. Improving interpretation services will provide improved care management and will empower providers and patients to have better communications regarding treatment which will lead to improved patient outcomes.

Challenges

[165] Koh, Howard, et al. "A Proposed 'Health Literate Care Model' Would Constitute A Systems Approach to Improving Patient Engagement in Care." Health Affairs 32 (2). February 2013: 357-367

A major challenge will be addressing health literacy and implementing the Health Literate Care Model across such a large health system. This will require immediate improvements in interpretation services including possible and effective consolidation of all interpretation services and balancing the current staff with needs for the service. All interpreters are expected to have the appropriate level of skill/expertise – it will take time to determine who requires more education/training and recruit the necessary number of interpreters and educate them as well.

Another challenge is to insure all appropriate AHRQ guidelines are addressed such that the Health Literate Care Model is incorporated into the chronic care model and the chronic care patient registry. A plan will insure success and will include timelines and budget for function to be at highest level of efficiency and competence.

5-Year Expected Outcome for Provider and Patients

The 5-year expected outcome is to improve health literacy for Parkland patients whose primary language is not English (specifically whose primary language is Spanish), which will be determined through results of the patient survey around communication with their providers.

Starting Point/Baseline

In FY2012, Parkland Interpretation Services provided 380,000+ encounters including calls and in-person services, to patients throughout the Parkland health system. More than 120,000 Parkland patients (290,000 total patients annually) speak Spanish as their primary language. Of those, based on responses to the 2012 patient satisfaction surveys:

- 76.5% said their physician always explained things in a way they could understand
- 69.1% stated their nurse explained things in a way they could understand

Rationale

In the United States, the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable health care is $1.24 trillion and more than 30% of direct medical costs for Hispanics, Asian Americans and African Americans and are excess costs due to health inequities.[166] Deeper review established across the four major language groups, that 23% of those who spoke a language other than English at home were those aged 18 to 40 who spoke Spanish. According to the 2007 American Community Survey[167], 40-45% of the population in Texas speaks a language other than English at home and speaks English less than "very well." More specifically, 42% of Parkland patients have a primary language is other than English, of which 39% of the patients spoke Spanish. And studies have shown that health disparities for Spanish-speaking Latinos are far more likely than for Latino and non-Latino English-speakers.

[166] LaVeist, TA, PhD; Gaskin, DJ, PhD; Richard, P, PhD. "The Economic Burden of Health Inequalities in the United States." September 2009.
[167] U.S. Census Bureau. "Language Use in the United States." American Community Survey. 2007.

Literature documents that problems with health literacy are associated with poor outcomes and those with less than adequate health literacy have less knowledge about their medical conditions and treatment, worse health status and higher rates of hospitalization.[168] A 1995 study in a large public hospital indicated that 61% of Spanish-speaking patients had inadequate or marginal health literacy. Results showed 42% did not understand directions regarding their medications, 43% did not understand the Medicaid application, specifically regarding their rights and 60% did not understand informed consent.[169]

Providing appropriate interpretation services has shown to improve health outcomes through improved communication with providers. Patients who have interpretation services available are more likely to ask questions about their care and better understand their role in their treatment plan. Additionally, those patients are more satisfied with their health care experience. One study showed that patients who rated their interpreter as "excellent" or "very good" also rated the health care they received highly.[170] Moreover, health care literature indicates that patients prefer and satisfaction gains are more evident when a professional in-person interpreter is used to communicate with patients, rather than lay staff and/or family, or telephone "language lines."[171] Parkland's interpretation services can better meet the needs of the patients through a more consistent and comprehensive program that insures clinicians and interpreters are appropriately trained to communicate with patients who require such services.

Project Components

There are no components for 1.4.7 – Other Project: Implement Health Care Literate Model. However, there are components that will be addressed for Project Option 1.4.1 including the following:

a) Identify and address language access needs and/or gaps in language access. *A plan for improved interpretation services will be developed. This plan will include the gap analysis for current needs and an implementation plan with timelines and accountabilities*. *Additionally, health literacy will be a major element in implementing the chronic care model at Parkland and in establishing appropriate transitions of care for LEP patients.*

b) Implement language access policies and procedures (in coordination with statewide and federal policies to ensure consistency across the state). *A review of regulatory requirements and current policies/procedures will be done and will direct modifications*

[168] Parker, R.M, Ratzan, S.C, Lurie, Nicole. "Health Literacy: A Policy Challenge For Advancing High-Quality Health Care." Health Affairs; July 2003; vol. 22 no 4; p 147-153

[169] Williams, M., et al., "*Inadequate Functional Health Literacy among Patients at Two Public Hospitals," Journal of the American Medical Association* 274, no. 21 (1995): 1677–1682.

[170] Green, A., Ngo-Metzger, Q., Legedza, A., Massagli, M., Phillips, P., Lezzoni, L. "*Interpretation Services, Language Concordance and Health Care Quality*." JIGM. June 28, 2005.

[171] Garcia, E., Roy, L., Okada, P., Perkins, S., Wiebe, R. *"A Comparison of the Influence of Hospital-Trained, Ad Hoc, and Telephone Interpreters on Perceived Satisfaction of Limited English-Proficient Parents Presenting to a Pediatric Emergency Department."* Pediatric Emergency Care. June 2004; vol. 20 no 6; p. 373-378.

to current policies and procedures as well as development of new policies/procedures as appropriate.

c) Increase training to patients and providers at all levels of the organization (and organization-wide) related to language access and/or cultural competency/sensitivity. *A review of the current competencies and needed competencies will be done. As a result of that review, Necessary training/education will be defined and new as well as current staff will be trained to meet required competencies*.

d) Increase interpretation services. *Necessary services will be identified through the gap analysis and will be addressed in the implementation plan.*

Milestones and Metrics

- P-4: Expand qualified health care interpretation technology
    - P-4.1: Video or audio conferencing interpreter terminals and/or areas/units of Performing Provider with access to health care interpretation technology
- P-7: Train a number or proportion of providers (and other staff) to appropriately utilize health care interpreters (via video, phone or in-person)
    - P-7.1: Expand language access utilization
    - P-7.2: Increase number of staff using available, qualified health care interpreters
- P-X: Utilize the Health Literacy Universal Precautions Toolkit to improve communications with patients as well as improve self-management and supportive systems for patients
    - P-X.1: Education/training for all interpreters and clinicians
    - P-X.2: Effective use of educational materials for patients
- I-13: Improve language access
    - I-13.1: Number of qualified health care interpreter encounters per month, based on one of the reporting months within the prior year
- P-11: Review project data and respond to it with tests of new ideas, practices, tools, etc.
    - P-11.1: Number of new ideas, practices, tools, solutions tested

- I-17: Milestone: Reduce wait time for interpretation encounters
    - I-17.1: The percentage of encounters in which the patient wait time for an interpreter is 15 minutes or less, as specified in *Speaking Together, National Quality Forum or similar* measures, or Average wait time for interpretation encounter, as measured by *Straight Talk: Model Hospital Policies & Procedures on Language Access, National Quality Forum or similar.*
- I-18: Milestone: Implement intervention to increase access to language services and culturally competent care
    - I-18.1: Increase percentage of target population reached

Unique Community Need Identification Numbers the Project Addresses

- *CN.1 Demographics*. Approximately 44% of Dallas Fort Worth residents are New Americans – defined as either foreign born or the children of foreign born and English is not the language spoken at home in 39% of North Texas homes.
- *CN.11 Patient Safety and Quality*. Research on health disparities and quality of care proves a correlation between those with health disparities and the care they receive.

How the Project significantly enhances an existing delivery system reform initiative

Parkland intends to improve the effectiveness of current interpretation services through development of a plan that will assess current/future need and current capabilities as well as determine implementation steps, timelines and accountabilities to improve those services.

The project has no related activities funded by U.S. Department of Health & Human Services.

Related Category 3 Outcome Measure(s)

OD-6: Percent improvement over baseline of patient satisfaction scores (2) to determine how well their doctors and nurses communicated (Stand-alone Measure)

- IT-6.1: Percent improvement over baseline of patient satisfaction for patients whose primary language is Spanish specific to the following questions on the survey:
    - "Nurse explained in a way I could understand"
    - "Physician explained in a way I could understand"

Reasons/Rationale for selecting outcome measures

People go to the doctor to be treated for an acute or chronic illness. If the provider does not communicate in way the patient can understand, the patient can leave disheartened, confused, and unsure regarding treatment instructions, medication regiments, etc. Parkland has a large number of patients who have a non-English primary language and while many of Parkland's providers are bi- or multi-lingual, there are still opportunities for miscommunication. Measuring patient's satisfaction regarding specific questions related to that communication will provide the basis to insure we are meeting their needs.

Relationship to Other Projects

This project covers care across the continuum and for all patients who require interpretation services but there are no similar proposed projects.

Category 4 Related Outcomes

- RD-4: Patient-centered Healthcare: Patient Satisfaction

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

There are no other RHP9 performing providers who have similar projects due to the specific needs of the Parkland patient population.

As appropriate, we plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 7.45 on a 9.00 scale. Influencing factors included:

- The large impact this project will have on improved communication with patients regarding their treatment (which will lead to improved outcomes)
- Alignment with the needs of the Dallas County population, of which many have a non-English primary language and require interpretation services

As much as 30.6% of direct medical care expenditures for African Americans, Asians and Hispanics were excess costs due to health inequalities to which language barriers are a major contributor.[172] The above analysis is applied in the following table to describe the potential excess costs that could be mitigated through this intervention.

Parkland Annual Direct Medical Costs (2013)	LEP Percent of Patient Population	Excess Cost Factor	Potential Excess Costs
$1,069,283,113	40%	30.6%	$130,880,253 (annual)
		Potential excess costs over 4 years	$523,521,012
		Category 2 and associated Category 3 Total Project Value	$33,561,302 (over 4 years)
		Percent Project Value to Potential Excess Costs	6.4%

[172] LaVeist, TA, PhD; Gaskin, DJ, PhD; Richard, P, PhD. "The Economic Burden of Health Inequalities in the United States." September 2009.

Unique Identifier: *127295703.1.7*	***Project Option:*** *1.4.7*	***Project Components:*** *1.4.7 - NA;*	***Title:*** *Implement Health Literate Care Model and Enhance Interpretation Services and Culturally Competent Care*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.39*	*3.IT-6.1*	*Percent Improvement over baseline for patient satisfaction scores related to (2) how well providers communicate*

Year 2 (10/1/2012 – 9/30/2013)	**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 Metric 1 [P-4.1]: Documentation of access to health care interpretation technology Goal: Expand technology Data Source: Automated report or other documentation Milestone 1 Estimated Incentive Payment (max amount): $3,449,541 **Milestone 2** [P-7] Train a number or proportion of providers (and other staff) to appropriately utilize health care interpreters Metric 2 [P-7.1]: Expand language access utilization Goal: Provide education system-wide through virtual learning and other media supports to increase awareness of program Data Source: Training program data Milestone 2 Estimated Incentive	**Milestone 3** [P-X] Utilize the Health Literacy Universal Precautions Toolkit to improve communications with patients as well as improve self-management and supportive systems for patients Metric 3 [P-X.1]: Education/training for all interpreters and clinicians Metric 4 [P-X.2]: Effective use of educational materials for patient Goal: Appropriate education/ training available to all interpreters/ clinicians/providers Data Source: Documentation of education/training available and provided to interpreters/clinicians and documentation of educational materials for patients Milestone 3 Estimated Incentive Payment (max amount): $3,528,060 **Milestone 4** [P-11] Review project data and respond to it with tests of new ideas, practices, tools, solutions. Metric 5 [P-11.1]: Number of new ideas, practices, tools, solutions tested	**Milestone 5** [I-13] Improve language access Metric 6 [I-13.1]: Number of qualified health care interpreter encounters per month, based on one of the reporting months within the prior year Baseline: 7,652 in-person and 18,231 language line calls (Nov 2012) Goal: Increase encounters by 10% Data Source: Automated report; other documentation Milestone 5 Estimated Incentive Payment (max amount): ~~$7,045,181~~ $3,522,590 **Milestone 6** [I-18]: Implement intervention to increase access to language services and culturally competent care Metric 7 [I-18.1]: Increase percentage of target population reached Goal: Incorporate elements into chronic care registry to address LEP issues/concerns	**Milestone 7** [I-13] Improve language access Metric 8 [I-13.1]: Number of qualified health care interpreter encounters per month, based on one of the reporting months within the prior year Goal: 20% over DY4 baseline Data Source: Automated report; other documentation Milestone 7 Estimated Incentive Payment (max amount): $2,844,327 **Milestone 8** [I-17] Reduce wait time for interpretation encounters Metric 9 [I-17.1]: Percentage of encounters in which patient wait time for an interpreter is 15 minutes or less Baseline/Goal: TBD/ Reduce by 10 min Data Source: Interpreter Services documentation Milestone 8 Estimated Incentive Payment (max amount): $2,844,328

Unique Identifier: *127295703.1.7*	***Project Option:*** *1.4.7*	***Project Components:*** *1.4.7 - NA;*	***Title:*** *Implement Health Literate Care Model and Enhance Interpretation Services and Culturally Competent Care*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.39*	*3.IT-6.1*	*Percent Improvement over baseline for patient satisfaction scores related to (2) how well providers communicate*

Year 2 (10/1/2012 – 9/30/2013)	**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 (max amount): $3,449,542	Data Source: Summarized quarterly Milestone 4 Estimated Incentive Payment (max amount): $3,528,060	Data Source: Chronic Care Registry Milestone 6 Estimated Incentive Payment (max amount): $3,522,591	
Year 2 Estimated Milestone Bundle Amount: $6,899,083	**Year 3 Estimated Milestone Bundle Amount:** $7,056,120	**Year 4 Estimated Milestone Bundle Amount:** $7,045,181	**Year 5 Estimated Milestone Bundle Amount:** $5,688,655
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):*			**$26,689,039**

Project Title: 1.8.1 - Expansion of Senior Dental Student Externship Program

RHP Project Identifier: 009784201.1.1

Performing Provider: Baylor College of Dentistry / 009784201

Project Description:

This project addresses **RHP Planning Protocol section 1.8: Increase, Expand and Enhance Oral Health Services**, **project option 1.8.1**: *Development of academic linkages with the three Texas dental schools, to establish a multi-week externship program for fourth year dental students to provide exposure and experience in providing dental services within a rural setting during their professional academic preparation.*

Summary

- Texas A&M Health Science Center / Baylor College of Dentistry (BCD) is the largest single provider of oral health care services in the Dallas/Fort Worth metropolitan area and dedicated to combining higher education and research with community service. Almost two-thirds of the dentists in the Dallas/Fort Worth area received their education at BCD, and more than one-third of all dentists in Texas are graduates of the college. The college completes more than 103,500 patient care visits annually, 45% of which benefit low-income individuals, and donates $3.3 million in services to the community. BCD students and faculty working in sponsored outreach programs outside the college provided an additional $1,400,000 in donated dental services for approximately 37,000 patients in the Dallas area.

- BCD proposes to increase the number of dental trainees with externship experience in rural and underserved areas of Texas, increase the total amount of externship experience each individual student receives, and increase the percentage of new dental graduates entering practice in rural and/or underserved areas.

- The target population for this project will be the patient population at the FQHCs, IHS and other community clinics providing dental care to the underserved throughout the state where BCD has internship agreements. The vast majority will be Medicaid patients, Medicaid-eligible and/or poor or indigent. A secondary target population will be the BCD students themselves, who will receive community-based clinical training at the internship sites.

- Category 1 or 2 outcome: Approximately 8,000 additional unduplicated patients over four years. Approximately 200 additional students participating in the internship program.

Improvement Milestone I-11.1: Increase dental care training

Metric 1: I-11.1 Increase the number of fourth year dental students that have participated in externships that provide experience in a rural setting

Customizable Improvement Milestone I-15: Increase the number of patients treated by fourth year dental students during externships

I-15.1. Metric: Number of patients treated by fourth year dental students during externship training opportunities

a. Numerator: Total number of patients treated by fourth year dental students during externship opportunities (with appropriate faculty oversight)

b. Denominator: Total number of patients treated during externship opportunities (by site staff only)

c. Data Source: Billing and treatment records

d. Rationale/Evidence: The externship training opportunities should expand the capacity of the site to provide dental services.

- Customizable Category 3 Outcome: Increasing the percentage of BCD graduates entering practice in rural or underserved areas to 10%.

Lack of dentists in some Texas counties, particularly in the rural areas, is a barrier for many children and adults. From 1991 to 2000, the number of dentists grew by 8.3 percent, while the population grew by 20 percent. The result was a 7.4 percent decrease in the number of dentists per 100,000 people. As of October 2012, there were approximately 13, 400 active dentists in Texas, yielding a ratio of dentists per 100,000 of 52.2. Unfortunately, the geographical distribution of dental practices across the state is distinctly uneven. The vast majority of dentists practice in and around the four major metropolitan areas of the state – Austin, Dallas-Ft. Worth, Houston and San Antonio.

The number of health-care providers available to service an area impacts the quality and quantity of health care received. The number of dentists is the primary indicator used to determine if an area is a Dental Health Professional Shortage Area (DHPSA). Currently more than 34 state public health programs use the Health Professional Shortage Area (HPSA) designation to determine eligibility for funding. Across Texas, more than 80 entire counties have been designated as DHPSAs, and 27 counties have been designated as partial DHPSAs. Areas with a ratio of less than one dentist for every 3,000 residents meet the "dentist to population ratio" requirement as specified in the federal designation eligibility criteria for a DHPSA. Other eligibility criteria used to establish a DHPSA include the area's poverty and fluoridation rates. These eligibility criteria are used to determine if an area has insufficient capacity to meet existing needs. An area's insufficient capacity is indicated by the time needed in advance of an appointment, number of patient visits during a full-time work week, and the number of providers not accepting new patients. According to the National Health Service Corps, Texas would need in excess of 700 additional dentists to achieve the recommended ratio of one dentist for every 3,000 residents. Moreover, the dentist-patient ratio seen among rural dentists is lower than among urban dentists. Low-income populations in rural areas thus are

potentially less likely to have access to dental care than low-income populations in urban areas. There are three schools of dentistry in Texas: Baylor College of Dentistry; University of Texas Health Science Center at Houston Dental Branch; and University of Texas Health Science Center at San Antonio Dental School. It is worth noting that all are located in a major metropolitan area.

BCD proposes to expand the existing externship program incrementally, by identifying new sites for externship programs, increasing the average length of the externships and recruiting a larger percentage of the senior dental class to participate in the program. Currently, about 40% (42 students) of the senior class participates annually, and there are 20 different opportunities to participate. The primary limiting factors for the program are funding and the relatively limited opportunity to participate, due to other training obligations. Currently this program is funded entirely by the Baylor Oral Health Foundation (the endowment fund of the dental school) and local funds available to the BCD department of Public Health Sciences, which oversees the program. There is no federal funding currently available to BCD to support this program. BCD has instituted changes in the clinical training program to include more off-campus training, as well as efforts to identify additional new sites/opportunities for participation.

By providing more training opportunities for dental students, the project has the potential to enhance recruitment and retention efforts of current and future dental providers in the rural and underserved areas of the state. Increased familiarity with the areas, personal experience with the overwhelming need for services in some areas and populations, increased familiarity with practice settings and opportunities and the potential for loan repayment should serve to influence students' decisions on where and how to enter practice.

Goals and Relationship to Regional Goals

Project Goals:

- Increasing the number of opportunities for multi-week externship opportunities in rural and/or underserved areas available to senior dental students at Baylor College of Dentistry / Texas A&M Health Science Center
- Increasing the number of students that participate in the externship program
- Increasing the percentage of new dental graduates entering practice in rural and/or underserved areas

Related regional goals:

- Increasing health care capacity and addressing healthcare access
- Reducing the prevalence of chronic diseases presenting early in life, that become more prevalent and exhibit more severe complications

- Reducing the high volume of patients with preventable conditions seeking care in emergency departments

Challenges

There are three major challenges that must be addressed in order to maximize the success of the project: 1) the highly structured dental curriculum that can limit students' participation in externship programs, 2) a somewhat limited number of sites available statewide for clinical training in the state, and 3) limited funding for the program.
With regard to the first issue, BCD has recognized the value of community-based clinical training and over the past five years embarked on a program to develop clinical externship programs in rural and underserved areas of the state. Curriculum changes have been initiated that allow students, particularly in the senior year, to participate more frequently and for longer periods than ever before. In concert with the curriculum changes, the College has negotiated with a number of federal, state, non-profit, church and community-based dental providers. As a result, a network of externship sites has been developed to service the student population. The challenge to the proposed project on this front is to expand the number of available sites, in order to accommodate the increased number of students participating in externship programs, and the increased average length of the externships. We are also proposing, as part of this project, to increase the funding for the externship program.

5 – Year Expected Outcome
BCD expects to 1) have establish 60 externship opportunities, 2) see class participation in externship programs rise to 90% by DY5, with the potential of as many as 100-200 new dental graduates over four years that have participated in the program, and 3) increase the percentage of new graduates entering practice in a rural and/or underserved area to 10%. The total number of patient encounters by the students over four year will be approximately 9,000, on approximately 8,000 unduplicated patients. We also anticipate that the percentage of new graduates entering practice in rural and/or underserved areas to rise to approximately 10%.

Interrelated Projects (Regional Goals)
N/A

Starting Point/Baseline
At the present time, senior class participation in Baylor's clinical training externship program is approximately 40% annually (42 students). We are able to offer 20 different opportunities for participation (some accommodating multiple students). The percentage of graduates who begin practice in a rural and/or underserved area currently averages approximately 5%.

Rationale

Unique community need identification numbers the project addresses

- CN.3 Healthcare Capacity
- CN.10 Dental Health
- CN.12 Emergency Department Usage and Readmissions

As documented in the RHP 9 Community Needs Assessment section CN.10 Dental Health, the disease burden of dental decay is high is many sectors of the populations, particularly minorities and low-socioeconomic groups. Dental decay is the most prevalent chronic disease in man, five times more common than asthma in children. Oral health problems are a major cause of school absences among elementary school children, and the seventh leading cause of workdays lost nationally. With regard to CN.3 Healthcare Capacity, this burden is exacerbated by dental manpower shortages in many areas of the state. Increased externship experience in rural/underserved areas will facilitate care of these populations, increase trainees' experience and familiarity with these populations and presumably increase recruitment and/or retention in these areas. Finally, the combination of disease prevalence, strategic manpower shortages and difficulties in general with access to dental care, a growing number of patients seek treatment for dental problems in the emergency departments of hospitals, most of which are not equipped to manage the problems. This adds to the expense of treatment and compounds the problems of already over-burdened emergency departments. Efforts to increase dental manpower, particularly in rural and underserved areas will serve to prevent emergency department visits for dental problems, addressing CN.12 Emergency Department Usage and Readmissions.

Related Category 3 Outcome Measure(s)

OD-7 Dental Health

- 3.IT-7.10 Percentage of new dental graduates entering practice in rural and/or underserved areas

As mentioned above, the disease burden of dental decay is high is many sectors of the populations, particularly minorities and low-socioeconomic groups. This burden is exacerbated by dental manpower shortages in many areas of the state. Increased externship experience in rural/underserved areas will facilitate care of these populations, increase trainees' experience and familiarity with these populations and presumably increase recruitment and/or retention in these areas. The combination of disease prevalence, strategic manpower shortages and difficulties in general with access to dental care, a growing number of patients seek treatment for dental problems in the emergency departments of hospitals, most of which are not equipped to manage the problems. This adds to the expense of treatment and compounds the problems of already over-burdened emergency departments.

This project will provide more training opportunities for dental students, with the potential to enhance recruitment and retention efforts of current and future dental providers in the rural and underserved areas of the state. Increased familiarity with the areas, personal experience with the overwhelming need for services in some areas and populations and increased familiarity with practice settings and opportunities and the potential for loan repayment should serve to influence students' decisions on where and how to enter practice. Therefore, the number of senior dental students electing to participate in one or more externships each year is proposed as an appropriate outcome measure for this project.

Relationship to Other Projects in RHP Plan

This project is part of an overall effort to increase the amount of community-based clinical training for our dental students, while serving the needs of our community. BCD has proposed three projects for the RHP plan. The other two projects involved expanded hours for community dental clinics utilizing BCD student clinicians, and expanding BCD's existing school-based dental sealant program.

Relationship to Other Performing Providers' Projects in RHP

Because we are the only dental performing provider, there is little relationship between this project and other providers' projects.

Plan for Learning Collaborative

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The valuation of this project is based primarily on the value of the care provided by the students during their externship trainings. The population addressed will be patients in rural/underserved areas who will be treated by the trainees, and will number approximately 8,000 over the four years of the project. Estimating the number students participating annually, and their production capacity, we conservative estimate an annual total of 2,250 patient encounters. Based on data from non-profit providers in the Dallas area and some of the current externship sites, the average cost of each encounter is approximately $125. A multiplier of 2.7, based on data from The Original National Dental Advisory Service 2012 (Yale Wasserman, D.M.D. Medical Publishers, Ltd. NDAS 30th Edition), will be applied to the average encounter cost. Calculation of this multiplier is based on Medicaid dental reimbursements by procedure

code versus the NDAS Comprehensive Fee Report, which is a nationwide marketplace analysis of usual and customary fees. The multiplier is also a way to incorporate the benefit to the community, in terms of addressing a high-priority community need, the size of the population served and the cost avoidance, e.g. reduced school absences, improved academic performance in children and decreased workdays lost due to dental complaints. Taken together, these figures estimate a total of $759,375 in treatment rendered during each year of the project.

009784201.1.1	*1.8.1*	*1.8.1*	*Expansion of senior dental student externship program*
Baylor College of Dentistry			9784201
Related Category 3 Outcome Measure(s):	*009784201.3.1*	*OD-7*	*IT-7.10 Percentage of new dental graduates entering practice in rural and/or underserved areas*

Year 2 (10/1/2012 – 9/30/2013)	**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 Enhance and expand dental care provider training: Metric 1: P-1.1 Increase externship training opportunities for fourth year dental students. *Baseline/Goal*: *20* / *30* *Data Source:* Externship opportunity descriptions Milestone 1 Estimated Incentive Payment: $180,351 **Milestone 2:** P-9 Review project data and respond to it every week with tests of new ideas, practices, tools or solutions Metric 1: P-9.1 Number of new ideas, practices, tools or solutions tested by each provider *Baseline/Goal*: 0/5 *Data Source:* Quarterly summary of ideas, practices, tools or solutions	**Milestone 5:** P-1: Enhance and expand dental care provider training: Metric 1: P-1.1 Increase externship training opportunities for fourth year dental students. *Goal*: *40* *Data Source:* Externship opportunity descriptions Milestone 5 Estimated Incentive Payment: $170,859 **Milestone 6:** P-9 Review project data and respond to it every week with tests of new ideas, practices, tools or solutions Metric 1: P-9.1 Number of new ideas, practices, tools or solutions tested by each provider *Goal*: 5 *Data Source:* Quarterly summary of ideas, practices, tools or	**Milestone 9:** P-1 Enhance and expand dental care provider training: Metric 1: P-1.1 Increase externship training opportunities for fourth year dental students. *Goal*: 50 *Data Source:* Externship opportunity descriptions Milestone 9 Estimated Incentive Payment: $161,367 **Milestone 10:** P-9 Review project data and respond to it every week with tests of new ideas, practices, tools or solutions Metric 1: P-9.1 Number of new ideas, practices, tools or solutions tested by each provider *Goal*: 5 *Data Source:* Quarterly summary of ideas, practices, tools or	**Milestone 13:** P-1 Enhance and expand dental care provider training: Metric 1: P-1.1 Increase externship training opportunities for fourth year dental students. *Baseline/Goal*: *60* *Data Source:* Externship opportunity descriptions Milestone 13 Estimated Incentive Payment: $151,875 **Milestone 14:** P-9 I Review project data and respond to it every week with tests of new ideas, practices, tools or solutions Metric 1: P-9.1 Number of new ideas, practices, tools or solutions tested by each provider *Goal*: 5 *Data Source:* Quarterly summary of ideas, practices, tools or

009784201.1.1	*1.8.1*		*1.8.1*	*Expansion of senior dental student externship program*
Baylor College of Dentistry				9784201
Related Category 3 Outcome Measure(s):	*009784201.3.1*	*OD-7*	*IT-7.10 Percentage of new dental graduates entering practice in rural and/or underserved areas*	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
tested. Milestone 2 Estimated Incentive Payment: $180,351 **Milestone 3:** I-11.1: Increase dental care training: Metric 1: I-11.1 Increase the number of fourth year dental students that have participated in externships that provide experience in a rural setting *Baseline/Goal*: *40 / 60* *Data Source:* Participation roster Milestone 3 Estimated Incentive Payment: $180,352 **Milestone 4:** I-15.1 Increase the number of patients treated by fourth year dental students during externships. Metric 1: I-15.1 Number of patients	solutions tested. Milestone 6 Estimated Incentive Payment: $170,859 **Milestone 7:** I-11.1: Increase dental care training: Metric 1: I-11.1 Increase the number of fourth year dental students that have participated in externships that provide experience in a rural setting *Goal*: 70 *Data Source:* Participation roster Milestone 7 Estimated Incentive Payment: $170,859 **Milestone 8:** I-15.1 Increase the number of patients treated by fourth year dental students during externships. Metric 1: I-15.1 Number of patients	solutions tested. Milestone 10 Estimated Incentive Payment: $161,367 **Milestone 11:** I-11.1: Increase dental care training: Metric 1: I-11.1 Increase the number of fourth year dental students that have participated in externships that provide experience in a rural setting *Goal*: *80* *Data Source:* Participation roster Milestone 11 Estimated Incentive Payment: $161,367 **Milestone 12:** I-15.1 Increase the number of patients treated by fourth year dental students during externships. Metric 1: I-15.1 Number of patients	solutions tested. Milestone 14 Estimated Incentive Payment: $151,875 **Milestone 15:** I-11.1: Increase dental care training: Metric 1: I-11.1 Increase the number of fourth year dental students that have participated in externships that provide experience in a rural setting *Goal*: *90* *Data Source:* Participation roster Milestone 15 Estimated Incentive Payment: $151,875 **Milestone 16:** I-15.1 Increase the number of patients treated by fourth year dental students during externships. Metric 1: I-15.1 Number of patients

009784201.1.1	*1.8.1*		*1.8.1*	*Expansion of senior dental student externship program*
Baylor College of Dentistry				9784201
Related Category 3 Outcome Measure(s):	*009784201.3.1*	*OD-7*	*IT-7.10 Percentage of new dental graduates entering practice in rural and/or underserved areas*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
treated by fourth year dental students during externships *Goal / Baseline*: 2250 / 1000 *Data Source:* EHR, clinic records Milestone 4 Estimated Incentive Payment: $180,352	treated by fourth year dental students during externships *Goal*: 2250 *Data Source:* EHR, clinic records Milestone 8 Estimated Incentive Payment: $170,860	treated by fourth year dental students during externships *Goal*: 2250 *Data Source:* EHR, clinic records Milestone 12 Estimated Incentive Payment: $161,367	treated by fourth year dental students during externships *Goal*: 225*0* *Data Source:* EHR, clinic records Milestone 16 Estimated Incentive Payment: $151,875
Year 2 Estimated Milestone Bundle Amount: $721,406	Year 3 Estimated Milestone Bundle Amount: $683,437	Year 4 Estimated Milestone Bundle Amount: $645,468	Year 5 Estimated Milestone Bundle Amount: $607,500
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,657,811			

Project Title: 1.8.6 - Expansion of Dallas County dental clinic hours
RHP Project Identifier: 009784201.1.2
Performing Provider: Baylor College of Dentistry / 009784201

Project Description:

This project addresses **RHP Planning Protocol section 1.8: Increase, Expand and Enhance Oral Health Services**, **project option 1.8.6:** *The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours.*

Summary

- Texas A&M Health Science Center / Baylor College of Dentistry (BCD) is the largest single provider of oral health care services in the Dallas/Fort Worth metropolitan area and dedicated to combining higher education and research with community service. Almost two-thirds of the dentists in the Dallas/Fort Worth area received their education at BCD, and more than one-third of all dentists in Texas are graduates of the college. The college completes more than 103,500 patient care visits annually, 45% of which benefit low-income individuals, and donates $3.3 million in services to the community. BCD students and faculty working in sponsored outreach programs outside the college provided an additional $1,400,000 in donated dental services for approximately 37,000 patients in the Dallas area.

- BCD proposes to increase the hours of operation at three community dental clinics in the Dallas area by placing senior dental students in community-based clinical training programs at the clinics.

- The target population for this project will be the patient population at the community clinics. The vast majority are Medicaid patients, Medicaid-eligible and/or poor or indigent. Approximately 80% of the patient population are pediatric patients. A secondary target population will be the BCD students themselves, who will receive community-based clinical training at the clinic.

- Category 1 or 2 outcome: Approximately 35,000 patient encounters over four years. Approximately 200 additional number of students participating in the internship program

- Category 3 Outcomes: Increase the percentage of children age 6-9 with a dental sealant on a permanent first molar tooth as follows; DY2: 28%, DY3: 29%, DY4: 31% and DY5: 32%.

  Increase the percentage of children age 0-6 who received a fluoride varnish application during the measurement period as follows; DY2: 28%, DY3: 29%, DY4: 31% and DY5: 32%. Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period as follows: DY2: 28%, DY3: 29%, DY4: 31% and DY5: 32%.

- Project metrics will be assessed by collection of oral health surveillance data using the appropriate module of the Basic Screening Survey. Key oral health status indicators relating to project outcome milestones will be captured directly onsite at Dallas elementary school campuses for children enrolled in Kindergarten, second and third grade. Direct data entry will be performed in the school-based sealant program using the SmilesMaker software, a modified version of the CDC's S.E.A.L.S. data collection tool. In both modules of the Basic Screening Survey, the assessment includes age-appropriate oral measures of oral health status including: untreated decay, urgency of care, caries experience, dental sealants, fluoride varnish applications and early childhood caries.

BCD proposes to expand the hours of operation in four clinics in the metropolitan area of Dallas, utilizing senior dental students in clinical externships.

Over the past two years, Baylor College of Dentistry has begun an initiative to increase the community-based clinical training program component of the clinic curriculum. The College has a long-standing collaboration with Community Dental Care, a non-profit dental provider operating 12 clinics in the Dallas area. In all, the program involves senior dental students rotating through four clinics; 1) Community Dental Care's Vickery Meadow dental center, 2) Community Dental Care's Grand Prairie dental center, 3) Community Dental Care's Bluitt-Flowers dental center, and 4) the dental clinic operated by Baylor College of Dentistry in the Dallas County Juvenile Detention Center.

Vickery Meadow dental center is currently open Monday-Friday, 8am-4:30pm. We propose to open the clinic 8am-4:30pm on Saturdays, with patients being seen by senior dental students under the supervision of BCD faculty. We conservatively estimate a total of 330 patient encounters annually, for a four-year total of 1,320.

Grand Prairie dental center will open in April of 2013, Monday-Friday, 8am-4:30pm, with one staff dentist. BCD dental students will rotate through the clinic one day per week year-round. We estimate the staff dentist will generate 3,000-4,500 patient encounters annually, with approximately 700 patient encounters by the dental students, for an annual total of 3,700 encounters. These rates will result in a total of between 15,000 and 16,000 patient encounters over the four-year course of the project.

Bluitt-Flowers dental center will expand hours in July 2013, Monday-Friday 8am-4:30pm, adding ten BCD dental students working in pairs. The students will generate approximately 1,200 patient encounters in DY2 and 5,700 annually thereafter, yielding a four-year total of approximately 18,000 encounters.

The Juvenile Detention Center clinic is currently operated four days per week, 10am-4:30pm, staffed by senior dental students working under the supervision of BCD faculty. We propose to

open the clinic an additional day per week, with a resultant increase of 312 patient encounters annually, for a four-year total of approximately 1,250 additional visits.

Clinic	Annual	Add'l patient encounters over 4 years
Vickery Meadow	330	1,320
Grand Prairie	3,700	15,000
Bluitt-Flowers	5,700	18,000
Juvenile Detention Center	312	1,250
Total	10,042	35,570

Expanding the hours of these clinics as described above will result in approximately 35,500 encounters more than currently provided.

Goals and Relationship to Regional Goals

Project Goal:

- Increasing access to dental care by extending the hours of operation of four dental clinics in the Dallas metropolitan area.

Related regional goals:

- Reducing the prevalence of chronic diseases presenting early in life, that become more prevalent and exhibit more severe complications
- Reducing the high volume of patients with preventable conditions seeking care in emergency departments

Challenges

The major challenges to the success of the project are the highly structured dental curriculum and crowded training program at the dental school, which limit students' participation in extramural training. BCD has recognized the value of community-based clinical training and over the past five years embarked on a program to develop clinical externship programs in rural and underserved areas of the state. Curriculum changes have been initiated that allow students, particularly in the senior year, to participate more frequently and for longer periods than ever before. In concert with the curriculum changes, the College has expanded its long-standing collaboration with Community Dental Care, a local non-profit dental provider with 12 clinics in the Dallas area. BCD proposes to expand its community-based clinical training program in order to provide student clinicians to staff the extended hours at Community Dental Care clinics and the Juvenile Detention Center clinic.

5 – Year Expected Outcome

Expanding the hours of these clinics as described above will result in approximately 35,500 encounters more than currently provided. All of these clinics serve primarily low socioeconomic status, underserved populations. A large majority (80%) of the patient population seen in the clinics are children age 5-20.

Interrelated Projects (Regional Goals)

N/A

Starting Point/Baseline

The current number of annual patient encounters at the Vickery Meadow clinic is approximately 4,000, for the Bluitt-Flowers clinic approximately 3000, and approximately 2,000 at the Juvenile Detention Center clinic. The Grand Prairie dental center is not yet open, so the baseline is effectively zero for that clinic.

Rationale

Unique community need identification numbers the project addresses

- CN.10 Dental Health
- CN.12 Emergency Department Usage and Readmissions

As documented in the RHP 9 Community Needs Assessment section CN.10 Dental Health, the disease burden of dental decay is high is many sectors of the populations, particularly minorities and low-socioeconomic groups. Dental decay is the most prevalent chronic disease in man, five times more common than asthma in children. Oral health problems are a major cause of school absences among elementary school children, and the seventh leading cause of workdays lost nationally. Finally, the combination of disease prevalence, strategic manpower shortages and difficulties in general with access to dental care, a growing number of patients seek treatment for dental problems in the emergency departments of hospitals, most of which are not equipped to manage the problems. This adds to the expense of treatment and compounds the problems of already over-burdened emergency departments. Efforts to increase dental manpower and improve access, particularly in rural and underserved areas will serve to prevent emergency department visits for dental problems, addressing CN.12 Emergency Department Usage and Readmissions.

Related Category 3 Outcome Measure(s)

OD-7 Dental Health

- IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth
- IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period
- IT-7.4 -Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period

As mentioned above, the disease burden of dental decay is high is many sectors of the populations, particularly minorities and low-socioeconomic groups. This burden is exacerbated by dental manpower shortages in many areas of the state. The combination of disease prevalence, strategic manpower shortages and difficulties in general with access to dental care, a growing number of patients seek treatment for dental problems in the emergency departments of hospitals, most of which are not equipped to manage the problems. This adds to the expense of treatment and compounds the problems of already over-burdened emergency departments. A large majority (80%) of the patient population seen in the clinics targeted in the project are age 5-20, thus outcome measures related to sealants, early childhood caries and topical fluoride application are appropriate.

Project metrics will be assessed by collection of oral health surveillance data using the appropriate module of the Basic Screening Survey. Key oral health status indicators relating to project outcome milestones will be captured directly onsite at Dallas elementary school campuses for children enrolled in Kindergarten, second and third grade. Direct data entry will be performed in the school-based sealant program using the SmilesMaker software, a modified version of the CDC's S.E.A.L.S. data collection tool. In both modules of the Basic Screening Survey, the assessment includes age-appropriate oral measures of oral health status including: untreated decay, urgency of care, caries experience, dental sealants, fluoride varnish applications and early childhood caries.

Relationship to Other Projects in RHP Plan

This project is part of an overall effort to increase the amount of community-based clinical training for our dental students, while serving the needs of our community. BCD has proposed three projects for the RHP plan. The other two involve increasing the number of dental students participating in internships in rural and/or underserved areas of the state, and expanding BCD's existing school-based dental sealant program.

Relationship to Other Performing Providers' Projects in RHP

Because we are the only dental performing provider, there is little relationship between this project and other providers' projects.

Plan for Learning Collaborative

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The valuation of this project is based primarily on the value of the care provided by the students during their rotations. The population seen in the clinics is overwhelmingly disadvantaged, underserved and of low-socioeconomic status, and will number approximately 10,000 over the four years of the project. Estimating the number students participating annually and their production capacity, we estimate an annual total of 3,300 patient encounters in DY2 and approximately 10,500 each year thereafter. Based on data from non-profit providers in the Dallas area and some of the current externship sites, the average cost of each encounter is approximately $125. A multiplier of 2.7, based on data from The Original National Dental Advisory Service 2012 (Yale Wasserman, D.M.D. Medical Publishers, Ltd. NDAS 30th Edition), will be applied to the average encounter cost. Calculation of this multiplier is based on Medicaid dental reimbursements by procedure code versus the NDAS Comprehensive Fee Report, which is a nationwide marketplace analysis of usual and customary fees. The multiplier is also a way to incorporate the benefit to the community, in terms of addressing a high-priority need, reducing school absences, improving academic performance in children and decreasing workdays lost due to dental complaints, the size of the population served and cost avoidance, as well as the benefit of additional clinical training for the dental students. Altogether, these figures estimate a total of over $1M in treatment during the first year of the project, and in excess of $3.6M each year thereafter.

009784201.1.2	*1.8.6.*	*1.8.6*	*Expansion of Dallas County dental clinic hours*
Baylor College of Dentistry			9784201

Related Category 3 Outcome Measure(s):	*009784201.3.2* *009784201.3.3* *009784201.3.4*	*OD-7*	*IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth.* *IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period.* *IT-7.4 -Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period.*

Year 2 (10/1/2012 – 9/30/2013)	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 Expand the hours of a dental care clinic or office, including both evening and/or weekend hours Metric 1: P-5.1 Increased number of hours at dental care clinic or office over baseline, number of patients served during extended hours Baseline/Goal: 112 / 150 Data Source: Clinic or office hour documentation, patient records, patient schedule Milestone 1 Estimated Incentive Payment: $503,702 **Milestone 2:** I-13 Increase access to rural and underserved areas of the state Metric 1: I13.1 Increased number of patients treated during expanded clinic hours Baseline/Goal: 9000 / 12,000 Patient encounters Data Source: Patient records, patient schedule	**Milestone 3:** P-5 Expand the hours of a dental care clinic or office, including both evening and/or weekend hours Metric 1: P-5.1 Increased number of hours at dental care clinic or office over baseline, number of patients served during extended hours Goal: 225 Data Source: Clinic or office hour documentation, patient records, patient schedule Milestone 3 Estimated Incentive Payment: $1,528,166 **Milestone 4:** I-13 Increase access to rural and underserved areas of the state Metric 1: I13.1 Increased number of patients treated during expanded clinic hours Goal: 10,000 additional encounters Data Source: Patient records, patient schedule Milestone 4 Estimated Incentive	**Milestone 5:** P-5 Expand the hours of a dental care clinic or office, including both evening and/or weekend hours Metric 1: P-5.1 Increased number of hours at dental care clinic or office over baseline, number of patients served during extended hours Goal: 300 Data Source: Clinic or office hour documentation, patient records, patient schedule Milestone 5 Estimated Incentive Payment: $1,658,424 **Milestone 6:** I-13 Increase access to rural and underserved areas of the state Metric 1: I13.1 Increased number of patients treated during expanded clinic hours Goal: 12,000 additional encounters Data Source: Patient records, patient schedule Milestone 6 Estimated Incentive	**Milestone 7:** P-5 Expand the hours of a dental care clinic or office, including both evening and/or weekend hours Metric 1: P-5.1 Increased number of hours at dental care clinic or office over baseline, number of patients served during extended hours Goal: 360 Data Source: Clinic or office hour documentation, patient records, patient schedule Milestone 7 Estimated Incentive Payment: $1,560,870 **Milestone 8:** I-13 Increase access to rural and underserved areas of the state Metric 1: I13.1 Increased number of patients treated during expanded clinic hours Goal: 12,000 additional encounters Data Source: Patient records, patient schedule Milestone 8 Estimated Incentive

009784201.1.2	*1.8.6.*	*1.8.6*	*Expansion of Dallas County dental clinic hours*	
Baylor College of Dentistry				9784201
Related Category 3 Outcome Measure(s):	*009784201.3.2* *009784201.3.3* *009784201.3.4*	*OD-7*	*IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth.* *IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period.* *IT-7.4 -Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period.*	
Year 2 (10/1/2012 – 9/30/2013)	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: $503,702	Payment: $1,528,166	Payment: $1,658,424	Payment: $1,560,870	
Year 2 Estimated Milestone Bundle Amount: $1,007,403	Year 3 Estimated Milestone Bundle Amount: $3,056,332	Year 4 Estimated Milestone Bundle Amount: $3,316,848	Year 5 Estimated Milestone Bundle Amount: $3,121,740	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $10,502,323				

Project Title: 1.8.9 - Expansion of school-based dental sealant program
RHP Project Identifier: 009784201.1.3
Performing Provider: Baylor College of Dentistry / 009784201

Project Description:

This project addresses RHP Planning Protocol section **1.8: Increase, Expand and Enhance Oral Health Services, project option 1.8.9:** *The implementation or expansion of school-based sealant and/or fluoride varnish programs that provide sealant placement and/or fluoride varnish applications to otherwise unserved school-aged children by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, local health departments (LHDs), federally qualified health centers (FQHCs), and/or local dental providers.*

Summary

- Texas A&M Health Science Center / Baylor College of Dentistry (BCD) is the largest single provider of oral health care services in the Dallas/Fort Worth metropolitan area and dedicated to combining higher education and research with community service. Almost two-thirds of the dentists in the Dallas/Fort Worth area received their education at BCD, and more than one-third of all dentists in Texas are graduates of the college. The college completes more than 103,500 patient care visits annually, 45% of which benefit low-income individuals, and donates $3.3 million in services to the community. BCD students and faculty working in sponsored outreach programs outside the college provided an additional $1,400,000 in donated dental services for approximately 37,000 patients in the Dallas area.

- BCD proposes to expand its school-based sealant and fluoride varnish program operating in the Dallas Independent School District and other suburban school districts.

- The target population for this project will be elementary school students (2nd and 3rd graders) in the Dallas Independent School District and various suburban school districts. More than 80% of DISD children are considered economically disadvantaged, far higher than the state figure of 59%. School campuses with an enrollment of at least 70% economically disadvantaged children will be eligible for participation. According to Basic Screening Survey data collected by the Texas Department of State Health Services in 2008, the last year for which data is available, 34% percent of Texas third-grade children had a sealant on at least one permanent molar tooth. In Dallas County, the figure was 28%. Children enrolled in Texas Medicaid and CHIP as well as those who are not eligible for public insurance will be served through the project. A secondary target population will be the BCD students themselves, who will receive community-based clinical training at the internship sites.

- Category 1 or 2 outcome: Project goals include incremental increases in DY3, DY4 and DY5, as measured by the number of unduplicated patients seen by the sealant program, and the number of elementary schools added to the program. Approximately 5,800 additional children will be screened and receive fluoride varnish applications, and more than 17,000 sealants will be placed over four years. The sealant program will be expanded from 45 to 60 or more elementary schools, and approximately 200 additional dental students will participate in the program.

- Category 3 Outcomes:

    - Increase the percentage of children age 6-9 with a dental sealant on a permanent first molar tooth: DY2: 28%, DY3: 29%, DY4: 31% and DY5: 32%.

    - Increase the percentage of children age 0-6 who received a fluoride varnish application during the measurement period: DY2: 28%, DY3: 29%, DY4: 31% and DY5: 32%.

    - Increase the percentage of children, age 0-20, who received a fluoride varnish application during the measurement period: DY2: 28%, DY3: 29%, DY4: 31% and DY5: 32%.

- Project metrics will be assessed by collection of oral health surveillance data using the appropriate module of the Basic Screening Survey. Key oral health status indicators relating to project outcome milestones will be captured directly onsite at Dallas elementary school campuses for children enrolled in Kindergarten, second and third grade. Direct data entry will be performed in the school-based sealant program using the SmilesMaker software, a modified version of the CDC's S.E.A.L.S. data collection tool. In both modules of the Basic Screening Survey, the assessment includes age-appropriate oral measures of oral health status including: untreated decay, urgency of care, caries experience, dental sealants, fluoride varnish applications and early childhood caries.

BCD proposes to expand its school-based sealant and fluoride varnish program operating in the Dallas Independent School District and other suburban school districts. Currently, the sealant program operates four days per week, with a staff of four dental students and a faculty supervisor. Over the past ten years, the program has visited approximately 45 schools each year, providing sealants and fluoride varnish applications for an average of 2,000 children annually. In DY2, operation of the program will expand to five days per week, with a target of 50 schools and 700 additional children treated. In DY3, we propose to purchase an additional vehicle and equipment, operating two sealant program teams five days per week. The number

of additional children seen annually in years DY2-DY5 will be approximately 1,800, for a total of 5,850 additional children screened and receiving fluoride varnish applications and more than 17,000 sealants placed over four years.

Goals and Relationship to Regional Goals

Project Goals:

- Increasing the number of elementary schools participating in the sealant program
- Increasing the number of patients seen in the sealant program

Related regional goals:

- Increasing health care capacity and addressing healthcare access.
- Reducing the prevalence of chronic diseases presenting early in life, that become more prevalent and exhibit more severe complications
- Reducing the high volume of patients with preventable conditions seeking care in emergency departments

Challenges

The challenges that must be addressed in order to maximize the success of the project are: 1) the highly structured dental curriculum that can limit students' participation in community-based clinical training programs, 2) the additional equipment required to expand the scope of the program, and 3) increased recruitment of students. With regard to the first issue, BCD has recognized the value of community-based clinical training and over the past five years embarked on a program to develop clinical externship programs in rural and underserved areas of the state. Curriculum changes have been initiated that allow students, particularly in the senior year, to participate more frequently and for longer periods than ever before. BCD proposes to purchase additional equipment in DY3, and to operate two sealant teams simultaneously. Finally, we have begun a program of education and training for Dallas Independent School District nurses, explaining the program and emphasizing the importance of oral health, the benefits of sealants, and encouraging the nurses to aid us in recruiting children for the program.

5 – Year Expected Outcome

BCD expects to deploy two sealant program teams, each operating five days a week, visiting approximately 60 elementary schools each year. The total number of patient receiving

screenings, fluoride varnish sealants over four years will be approximately 5,800, and more than 17,000 sealants.

Project metrics will be assessed by collection of oral health surveillance data using the appropriate module of the Basic Screening Survey. Key oral health status indicators will be captured directly on site at Dallas elementary school campuses for children enrolled in Kindergarten, second and third grade. Direct data entry will be performed in the school-based sealant program using the SmilesMaker software, a modified version of the CDC's S.E.A.L.S. data collection tool. In both modules of the Basic Screening Survey, the assessment includes age-appropriate oral measures of oral health status including: untreated decay, urgency of care, caries experience, dental sealants, fluoride varnish and early childhood caries.

Interrelated Projects (Regional Goals)

N/A

Starting Point/Baseline

At the present time, the sealant program visits approximately 45 schools each year, treating an average of 2,000 children annually.

Rationale

Unique community need identification numbers the project addresses

- CN.10 Dental Health
- As documented in the RHP 9 Community Needs Assessment section CN.10 Dental Health, the disease burden of dental decay is high is many sectors of the populations, particularly minorities and low-socioeconomic groups. Tooth decay (dental caries) is the most common chronic childhood disease. Dental caries can have serious consequences, including the loss of tooth structure, inadequate tooth function, unsightly appearance, pain, infection, and tooth loss. If left untreated, the pain and infection of tooth decay can lead to problems in eating, speaking, and learning. Annually, an estimated 51 million school hours across the nation are lost because of dental-related illness (U.S. DHHS 2000a). Tooth decay is five times more common than asthma and seven times more common than hay fever (U.S. DHHS 2003). The prevalence of tooth decay is not uniformly distributed in Texas. Some groups of children, such as those from low-income or minority families, are more likely to experience the condition. Past research consistently shows an inverse relationship between parents' socioeconomic status and children's tooth decay. Children from low-income and minority families often have poorer oral health outcomes, fewer dental visits, and fewer protective sealants. The prevalence of the caries experience, including untreated decay, is higher among six-to-

eight-year-old children in Texas compared to six-to-eight-year-old children in the United States. For dental care by racial/ethnic category, Texas is lower than national averages among white and Hispanic children and adolescents. National averages for preventive dental visits among children and adolescents are higher for both boys and girls as compared to boys and girls in Texas. School-based dental sealant programs have been identified by the CDC as a preventive measure that has strong evidence demonstrating effectiveness in the prevention of dental caries and allow for low-income high risk children to receive dental sealants that otherwise may not have the opportunity to receive them. Measuring increases in special high risk populations accessing dental services reflects the goals of addressing health disparities in access to dental care.

Related Category 3 Outcome Measure(s)

OD-7 Dental Health

- IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth
- IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period
- IT-7.4 -Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period

Community water fluoridation is by far the most cost-effective means of preventing dental decay. Since the public water supply in Dallas is fluoridated, the next most cost-effective measures are sealants and topical fluoride. In children for whom access to care is problematic, sealants and fluoride varnish are the most practical and cost-effective preventive treatments, particularly when delivered in school-based programs. The patient population targeted by the sealant program is children age 6-9, thus outcome measures related to sealants and topical fluoride application are appropriate.

Project metrics will be assessed by collection of oral health surveillance data using the appropriate module of the Basic Screening Survey. Key oral health status indicators relating to project outcome milestones will be captured directly onsite at elementary school campuses for children enrolled in Kindergarten, second and third grade. Direct data entry will be performed in the school-based sealant program using the SmilesMaker software, a modified version of the CDC's S.E.A.L.S. data collection tool. In both modules of the Basic Screening Survey, the assessment includes age-appropriate oral measures of oral health status including: untreated decay, urgency of care, caries experience, dental sealants, fluoride varnish applications and early childhood caries.

Relationship to Other Projects in RHP Plan

This project is part of an overall effort to increase the amount of community-based clinical training for our dental students, while serving the needs of our community. BCD has proposed three projects for the RHP plan. The other two involve increasing the number of dental students participating in internships in rural and/or underserved areas of the state, and expanded hours for community dental clinics utilizing BCD student clinicians.

Relationship to Other Performing Providers' Projects in RHP

Because we are the only dental performing provider, there is little relationship between this project and other providers' projects.

Plan for Learning Collaborative

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The valuation of this project is based primarily on the value of the care provided by the students participating in the school-based sealant program. The population addressed will be second and third grade elementary students in the Dallas and suburban school districts, and the added number treated over the four years of the project will be approximately 5,800. Data from the sealant program, collected over the past ten years, indicates that an average of three sealants are placed in each patient encounter, yielding a total of 17,000 additional sealants placed over the four years of the project, relative to baseline. Based on data from non-profit providers and private practitioners in the Dallas, the average fee for sealants is approximately $30 each. For purposes of this valuation, the cost of screenings and fluoride varnish application is not included. A multiplier of six, higher than for restorative treatment, will be applied to the cost of each sealant. The multiplier incorporates the additional benefit of the fluoride varnish application, the benefit to the community in terms of addressing a high-priority need, reducing school absences and improving academic performance in children, the size of the population served and cost avoidance. Cost avoidance, in terms of treatment averted, is particularly high for sealants. Data from studies of the efficacy, cost-effectiveness and cost-benefit of dental preventive interventions estimate that preventing decay on a tooth can avoid restorative treatment that, over a period of as short as ten years, can total as much as $2,800 per tooth,

more than 90 times the cost of the sealant. Calculations based on cost, the number of sealants placed annually and the value multiplier estimate a total of $355,509 of care delivered in DY2 and approximately $928,000 each year thereafter.

009784201.1.3	*1.8.9*	*1.8.9*	Expansion of school-based dental sealant program
Baylor College of Dentistry			9784201

Related Category 3 Outcome Measure(s):	*009784201.3.5* *009784201.3.6* *009784201.3.7*	*OD-7*	*IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth* *IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period* *IT-7.4 -Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: P-6 Implement/expand alternative dental care delivery systems to underserved populations Metric 1: P-6.3 Expand school-based sealant program Baseline/Goal (Number of schools participating): 45 / 50 Data Source: MOUs, contracts Milestone 1 Estimated Incentive Payment: $177,754 **Milestone 2:** I-14 Increase number of special population members that access dental services Metric 1: I-14.2 Number of children seen by dental provider within past 12 months Baseline/Goal: 2000 / 2,700 children seen Data Source: Consent forms Milestone 2 Estimated Incentive Payment: $177,754	**Milestone 3:** P-6 Implement/expand alternative dental care delivery systems to underserved populations Metric 1: P-6.3 Expand school-based sealant program Goal: 55 Data Source: MOUs, contracts Milestone 3 Estimated Incentive Payment: $417,717 **Milestone 4:** I-14 Increase number of special population members that access dental services Metric 1: I-14.2 Number of children seen by dental provider within past 12 months Goal: 1,800 additional children seen Data Source: Consent forms Milestone 4 Estimated Incentive Payment: $417,717	**Milestone 5:** P-6 Implement/expand alternative dental care delivery systems to underserved populations Metric 1: P-6.3 Expand school-based sealant program Goal: 60 Data Source: MOUs, contracts Milestone 5 Estimated Incentive Payment: $394,510 **Milestone 6:** I-14 Increase number of special population members that access dental services Metric 1: I-14.2 Number of children seen by dental provider within past 12 months Goal: 1,800 additional children seen Data Source: Consent forms Milestone 6 Estimated Incentive Payment: $394,510	**Milestone 7:** P-6 Implement/expand alternative dental care delivery systems to underserved populations Metric 1: P-6.3 Expand school-based sealant program Goal: 60 Data Source: MOUs, contracts Milestone 7 Estimated Incentive Payment: $371,304 **Milestone 8:** I-14 Increase number of special population members that access dental services Metric 1: I-14.2 Number of children seen by dental provider within past 12 months Goal: 1,800 additional children seen Data Source: Consent forms Milestone 8 Estimated Incentive Payment: $371,304

009784201.1.3	*1.8.9*		*1.8.9*	Expansion of school-based dental sealant program
Baylor College of Dentistry				9784201
Related Category 3 Outcome Measure(s):	*009784201.3.5* *009784201.3.6* *009784201.3.7*	*OD-7*	*IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth* *IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period* *IT-7.4 -Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period*	

Year 2 (10/1/2012 – 9/30/2013)	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: $355,509	Year 3 Estimated Milestone Bundle Amount: $835,434	Year 4 Estimated Milestone Bundle Amount: $789,021	Year 5 Estimated Milestone Bundle Amount: $742,608
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,722,572			

Project Option 1.1.2 – Increase access to primary care – Continuing Care Clinic

Unique Project ID: 020908201.1.1
Performing Provider Name/TPI: Texas Health Presbyterian Hospital Dallas/020908201

Provider: Texas Health Presbyterian Hospital Dallas, part of the Texas Health Resource system, serves a 621.5 square mile area and a population of approximately 2,054,356 people.

Intervention(s): This project will reduce the use of the emergency department by targeting specific individuals with high utilization rates.

Need for the project: We have one physician who will only work specific hours. Need additional staff and resources.

Target population: The target population is patients with three or greater inappropriate ED visits within 1 year, inpatients who need appropriate follow-up care post discharge, and patients who visit the ED that could avoid an inpatient observation admission if there was appropriate follow-up care available.

Category 1 expected patient benefits: This project seeks to provide a bridge from the emergency room to primary care offices.

Category 3 outcomes: IT-3.3 our goal is to reduce the 30-day Diabetes readmission rate by 15%

- IT-3.10 our goal is to reduce the 30-day Adult Asthma readmission rate by 15%
- IT-9.2 our goal is to reduce inappropriate ED utilization by 18%

Project Description

The Continuing Care Clinic (CCC) will provide an alternative lower cost setting of care for patients in the emergency department that are there inappropriately. The patient population will be a convenience sample of unfunded patients with 3 or more visits to the ED in one year. The patients will be directed to an internist, Physician Assistant, or Nurse Practitioner by the ED physician for follow-up care. When the patient does not need urgent or emergent are in the ED or be admitted, the physician will direct them to the CCC. The clinic setting will be in the fast track location of the ED. The Continuing Care Clinic will serve several groups of self-pay patients:

- Patients with 3 or greater inappropriate ED visits within 1 year
- Inpatients who could be discharged sooner if there was appropriate follow up care available

- Patients with an ED visit who could avoid an inpatient or observation admission if there was appropriate follow up care available

Goals and Relationship to Regional Goals

Project Goals

The goals of this project are:

- Reduce inappropriate ED utilization due to lack of access to PCP care
- Enhance timely, safe discharge from inpatient/observation admission/provide follow up care
- Avoid "soft admissions" i.e. patient who are admitted to the hospital due to lack of adequate follow up care because of financial constraints

This project meets the following regional goals:

The plan is to expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. Our five-year target goal is to substantially decrease the number of emergency department visits, costs associated with visits, and the number of admissions for ED frequent flyers by 18% over the next 5 years. There are a number of patients who are frequent flyers to our ED and are admitted to the hospital within 30 days of their last admission for the same condition. This clinic will provide follow-up care to unfunded patients in a timely manner in an outpatient setting (instead of an ED setting) or assure navigation to another medical home. The overall goal of the project is to reduce ED utilization and readmissions.

Challenges

Texas Health Dallas faces several challenges because THD has a large number of patients who utilize the ED as their source of primary care due to a lack of insurance. The Continuing Care Clinic (CCC) will serve as primary care and will assure referral to another available resource for primary care.

5-Year Expected Outcome for Provider and Patients

The 5-year expected outcomes are:

- Improvement in patient outcomes due to improved compliance with treatment plans

- Decrease in volume of inappropriate uninsured ED visits
- Decrease in self-pay, bad debt and write offs for this population due to a decrease in inappropriate ED utilization

Starting Point/Baseline

The Continuing Care Clinic opened an original location within our ED on October 30, 2012 as an extension of the ED "fast track" location but decided due to space and lack of staff, to move the Continuing Care Clinic to our THD JIMC (Jackson Internal Medicine Clinic) in one of our Professional Buildings connected to the hospital. This new location has ample space for privacy with 15 exam rooms and a nurse's station. It is staffed 6 hours/day 5 days a week by a bilingual internal medicine physician and ED SW Case Managers as needed. The hours of operation are yet to be determined.

We will use 2011 data for the baseline and look at the number of patient visits, associated cost, and number of admissions of the patients who frequently come to the ED.

Continuing Care Clinic	2012	2013 YTD
# of Patients Seen	36	31

Rationale

This project will provide a model for health care delivery of the unfunded, patient population and will achieve a higher quality of life for these patients (decreased sick days, decreased work days missed, decreased cost, decreased risk of complications and decrease in utilization of ED for primary care). In addition, it will demonstrate a decrease in unfunded readmissions and in bad debt load for the hospital.

As cited in the Texas Medical Association – Physicians Caring for Texans, 2009-2010 publication, Texas is the uninsured capital of the United States. For adults (ages 19-64), Texas ranks highest in uninsured rates. The CCC can help by providing primary care for the uninsured population by providing primary care directly or by assuring that the patient is secure in a medical home.

Project Components

The CCC will meet both patient and institutional needs by providing a place for patients that over utilize the ED to receive care in the right setting at a lower cost.

Unique community need identification numbers the project addresses

- CN.3: Healthcare Capacity
- CN.4: Primary care and pediatrics

- CN.8: Specialty care
- CN.11: Patient Safety and Quality

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

This project would utilize case findings and preventative care for this patient population. It will allow for meeting patient needs before a crisis occurs and teach the patient how to avoid a future crisis.

Related Category 3 Outcome Measures

- IT-3.3: Diabetes 30 day readmission rate
- IT-3.10: Adult Asthma 30 day readmission rate
- IT-9.2: Appropriate ED Utilization

Reasons/Rationale for selecting outcome measures

The prevalence of diabetes and therefore the associated mortality and morbidity have steadily increased (Texas Behavioral Risk Factor Surveillance System 2010) and with increasing numbers of unemployed and uninsured in Texas, there is every reason to believe this population will continue to be uninsured and to use the ED for primary care. A study completed at Columbus Regional Medical Center , Columbus, Georgia , published in "Clinical Diabetes" July 2003, vol 21, no 3, 136- 139, developed a model of inpatient diabetes support designed to reduce inpatient lengths of stay, but more importantly to reduce recidivism rates. This study stratified the diabetic patient needs into 5 "needs" categories. They found that the biggest need was "social and economic service rather than diabetes education." Their program was successful readmission decreased by 74%. This approach will decrease readmissions and visits to the ED.

Asthma is one of the most prevalent chronic diseases in Texas with an estimated 2.2 million (12.2%) reporting lifetime asthma and 1.3 million reporting current asthma. The hospitalization rate in Texas in 2007 was 10.9 per 10000 Texas residents and accounted for an estimated $446.8 million in hospital charges (TX Dept. of Health Services, 4/12). Goals of a study done at Presbyterian Hospital of Dallas in 1997 were to enhance patient self-management through education and follow up, decrease ED visits and support physician treatment plan. All three of the goals were met by using the Asthma Management Program as an adjunct after ED care. The CCC patients will be referred to this program post ED visit. This approach will decrease readmissions and visits to the ED.

Currently in 2012, THD ED staffing is being overwhelmed by large increase of patients entering our ED on a daily bases. The needs of the patients stay consistent but becoming increasingly difficult to manage when specific patients regularly enter our facility for minor or easily manageable health issues. To manage the volume of patients that are coming through our

facilities door, THD ED will need to improve how we utilize our clinical staff as well as reorganize and reprioritize how our clinical staff cares for our patients. Not to minimize the amount of care given but to focus ED's resources to increase care for critical care patients and divert low acute care patients to appropriate staff. The graph below shows the increase in patients as well as how much uninsured patients cost THD.

ED Volume	**2011**	**2012**
# of Patient Visits / Mthly Avg.	76,427 / 6,368	83,888 / 6,990
ED Patients with 3 or < Visits	**2011**	**2012**
# of Patients / # of Visits	3,936 / 16,170	4,627 / 19,486
# of Uninsured / # of Visits	1,112 / 4,644	1,407 / 5900
Direct Cost of Uninsured	$1,912,345	$1,824,190
Charity Sum of Uninsured	$5,297,373	$7,627,350
Staffing	**2011**	**2012**
Staffing OT Cost / Mthly Avg.	$526,443.4/ $43,810	$360,382.3/ $45,047

Relationship to other Projects

This project is related to the Faith Community Nursing/Health Worker Project (020908201.2.2) and Healing Hands Ministries (020908201.2.3). Both of these project goals are to reduce admissions and lower the overall cost of healthcare to the individual and system. These projects will work in tandem with each other to provide access to care unfunded patients.

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

This project is establishing a continuity clinic within the ED and is related to other projects that address primary and specialty care but no other project is specific to providing such services within the ED. Baylor Garland (121790303.1.1), Baylor Irving (121776204.1.1), BUMC (139485012.1.1), Children's (1389100807.1.2), and UTSW (126686802.1.2) all have projects in the same category.

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable use to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

For every inpatient readmission avoided, $6,285 in cost is saved by the healthcare system[173]. Healthcare costs are calculated by multiplying $6,285 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

For every inpatient readmission avoided, $8,297 in cost is saved by the healthcare system[174]. Healthcare costs are calculated by multiplying $8297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.
For every inpatient readmission avoided, $8,297 in cost is saved by the healthcare system[175]. Healthcare costs are calculated by multiplying $8297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs. Inpatient readmissions outcome improvement targets are dependent on the target population served (e.g. aging populations will have increased admissions due to higher incidence rates), size (e.g. if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable readmissions (e.g. keeping lower acuity patients under observation instead of admitting them).

[173] Texas Department of State Health Services with 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm
[174] Texas Department of State Health Services with 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm
[175] Texas Department of State Health Services with 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

020908201.1.1	***1.1.2***	***1.1.2 (A-C)***	***Title:*** *Continuing Care Clinic*	
Texas Health Presbyterian Hospital Dallas				*020908201*
Related Category 3 Outcome Measure(s):	*020908201.3.1* *020908201.3.2* *020908201.3.3*	*IT-3.3* *IT-3.10* *IT- 9.2*	*Diabetes 30 day readmission rate* *Adult Asthma 30 day readmission rate* *Appropriate ED Utilization*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Establish additional primary care clinics Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Baseline: Main Clinic Opened Dec '12 (Opened temp. clinic within ED on Oct 30 '12) Open clinic by 4th quarter, 2012, 4 hours/day x 5 days/week based on highest patient need/volume Baseline: 67 pts in 3 Months (Oct 30 2012 – Feb 14 2013) Goal: 130 pts in 3 months Milestone 1 Estimated Incentive Payment: $1,440,674	**Milestone 2** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites Baseline/Goal: 1 prov x 4 hrs/day x 5 days/week Data Source: Financial - EPSI Milestone 2 Estimated Incentive Payment: $697,441 **Milestone 3** [P-4]: Expand the hours of primary care clinic Baseline: 2012 – Main Clinic opened 6 hours/day x 5 days/week Data source: clinic documentation Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline Data source: clinic documentation Milestone 3 Estimated Incentive Payment: $697,442		**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period Goal: 25% increase of volume over baseline Data Source: EMR – EPIC (CareConnect) Metric 2 [I-12.2]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care. Goal: Increase unique patients by 10% of baseline	**Milestone 5** [I-15]: Increase access to primary care capacity: Metric 1 [I-15.1]: Increase percentage of target population reached (patients with the 3 or greater ED visits/year) Numerator: Number of individuals of target population reached by the innovative project Denominator: Number of individuals in the target population Goal: 50% of targeted pt population Data Source: Financial - EPSI Metric 2 [I-15.3] Documentation of increased number of unique patients, or size of patient panels: a. Total number of unique patients encountered in the clinic for reporting period. b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care. Goal: Increase unique patients by 15% of baseline

020908201.1.1	***1.1.2***	***1.1.2 (A-C)***	***Title:*** *Continuing Care Clinic*	
Texas Health Presbyterian Hospital Dallas				*020908201*
Related Category 3 Outcome Measure(s):	*020908201.3.1* *020908201.3.2* *020908201.3.3*	*IT-3.3* *IT-3.10* *IT- 9.2*	*Diabetes 30 day readmission rate* *Adult Asthma 30 day readmission rate* *Appropriate ED Utilization*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Data Source: EMR – EPIC (CareConnect) Milestone 4 Estimated Incentive Payment: $1,471,184	Data Source: EMR – EPIC (CareConnect), Financial- EPSI Milestone 5 Estimated Incentive payment: $1,187,912
Year 2 Estimated Milestone Bundle Amount: **$1,440,674***		Year 3 Estimated Milestone Bundle Amount: **$1,394,883***	Year 4 Estimated Milestone Bundle Amount: **$1,471,184***	Year 5 Estimated Milestone Bundle Amount: **$1,187,912***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $5,494,653				

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Project Option 1.1.1 - Establishing a New Primary Care Community Outreach Center

Unique Project ID: 126686802.1.1
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW") Faculty Practice Plan/126686802

Summary Information
Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds in the St. Paul and Zale Lipshy Hospitals and 40 clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. Between December 2010 and November 2011, UTSW physicians provided care to Charity and Medicaid patients during 16,175 visits which were specifically at UT Southwestern outpatient practices.

Intervention(s): UTSW will establish a new Primary Care Clinic staffed by two General Internal Medicine physicians and at least two physicians in Obstetrics & Gynecology. As volume and demand warrants it, evening and weekend hours are planned to improve access and capacity.

Need for the Project: As an academic medical center, we currently have a limited capacity in primary care services. The Community Needs Assessment for RHP 9 identifies the lack in primary care capacity, in addition high emergency department utilization for ambulatory conditions, to be areas of particular concern to the Region.

Target Population: The primary service area is everyone living within a 5 mile radius of the clinic. Approximately 5% of our patients are either Medicaid eligible or indigent, so we expect they will benefit from about 5% of the primary care services.

Category 1 or 2 Expected Patient Benefits: The project seeks to provide increased primary care access with approximately 20,000 patient visits each year, with approximately 8,000 unique patients becoming part of the Clinic's panel. Approximately 1000 visits and 400 patients are projected to be Medicaid and low income patients.

Category 3 Outcome Measures:

- IT-12.1 Breast Cancer Screening— By DY5, our goal is to increase the number of women aged 40 to 69 that have received an annual mammogram by X% (TBD) above the DY2 baseline.

- IT-12.3 Colorectal Cancer Screening—By DY5, our goal is to increase the number of adults aged 50 to 75 that have received colorectal cancer screening by X% (TBD) above the DY2 baseline.

- IT-12.4 Pneumonia Vaccination Status of Older Adults—By DY5, our goal is to increase the number of patients who are older adults receiving a pneumonia vaccination by X% (TBD) above the DY2 baseline.

Project Description

UT Southwestern Medical Center is in the process of establishing a new multispecialty clinic in Dallas County that is comprised of both Primary Care and Specialty Care Services. **This proposal addresses solely the Primary Care Clinic Services.** The Primary Care Clinic components are planned to provide two physicians in General Internal Medicine and at least two physicians in Obstetrics & Gynecology. The Primary Care Clinic area will be approximately 6,500 square feet and will include ultrasound, blood drawing space, plain film x-rays, and mammography.

The new clinic will have an electronic medical record that immediately will be integrated into the main UT Southwestern electronic medical record system. This will facilitate and increase referrals to other UT Southwestern specialists, clinics, and sophisticated diagnostic capabilities. Referrals within the system will be tracked.

UT Southwestern will recruit additional physicians to the Faculty Practice Plan to staff this clinic, which in turn will increase the capacity of UT Southwestern Medical Center and RHP 9 to see more patients in new locations. The new location, at Hillcrest and Northwest Highway, will make it easier for patients to access the new providers and services. Parking at the new location is free and easily accessible. The site is also convenient to public transportation from the DART System bus and train lines.

While we do not contemplate training residents at the new location during the first year, the clinic would provide an ideal setting to train medical students and residents in how to practice in a traditional community setting.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals:

The project goals are as follows:

- Add one additional primary care clinic to be located in the Hillcrest/Northwest Highway area, specifically Hillcrest Crossing.

- Train/hire additional primary care providers and staff.
- Expand the hours at the primary care clinic to include evening and/or weekend hours.
- Over time, increase primary care clinic volume of visits and number of unique patients seen.

This project also meets the following regional goals:

RHP 9 has a primary care provider and capacity shortage. This project addresses increasing access to primary care services and providing high quality, comprehensive care to patients in a less costly setting—a primary care clinic. Emergency Department utilization is unnecessarily high in RHP 9. By providing more patients with the accessible primary care they need, ED utilization should be less.

Challenges

New medical services in new locations face two substantive challenges. First, the community must be made aware of the new clinic and the types of physician services that are available. The second challenge is projecting the appropriate range and level of services to be provided based on demand/need assumptions. A marketing plan is being developed to announce the new Clinical Center that is designed to reach the target populations using web-based and print-based media targeted at service area referring physicians, households, and local newspapers. Based on the Community Needs Assessment, primary care services will be provided on a graduated basis and regulated by the response from the service area community. Other service enhancements will be evaluated based on patient feedback and market demands.

5-Year expected outcome for Provider and Patients:

By the end of Year 5, we hope to have at least three Internal Medicine and two Ob/Gyn physicians practicing full time. We project seeing up to 25,000 patient visits each year, with approximately 8,000 unique patients becoming part of the Clinic's panel. Given the patient-centered approach planned for the Clinic, we project improved outcomes consistent with our goals for Category 3 measures.

Starting Point/Baseline

The new "UTSW Clinical Center at Park Cities" is in the fast-track design-build process. The new clinic is scheduled to open in January 2013. As a result, the baseline is zero for the number of clients served by the project. Projections for unique patients and patient visit volumes in Year 1 of operations are still being determined.

The clinic will require UT Southwestern to recruit new physicians in Internal Medicine, Obstetrics & Gynecology, and selected other specialties depending upon demand. In addition, once the new clinic reaches certain growth projections, evening and weekend hours are planned to further improve access to services.

Rationale

UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, UT Southwestern's Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, UT Southwestern physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices. Thus, UT Southwestern physician services are directly impacted by inadequate availability of primary care services.

The RHP 9 Community Needs Assessment Report states, "The demand for primary and specialty care services exceeds that of available medical physicians in these areas, thus limiting healthcare access for many patients needing low level management or specialized treatment for prevalent conditions." In addition, the top five prevalent conditions found in the Emergency Department encounters included hypertension and diabetes which are conditions that could be better managed in ambulatory clinics rather than episodically in hospital Emergency Departments. There is also a significant demand for access to prenatal care in our region. Finally, the report provides data showing that Dallas County has significant HPSA (Health Professions Shortage Areas) and MUA (Medically Underserved Areas) regions that overlap. In order to expand capacity, more primary care and specialty care physicians need to be trained in and/or recruited to Dallas County. At the same time, these physicians need to be distributed more widely to improve access by the patients of RHP 9.

UT Southwestern selected this project, because the project adds a new primary care clinic in the community, increases availability of primary care providers and selected specialists, improves access to primary care and selected specialists, and improves service availability. All patient populations have difficult gaining timely access to primary care physicians and specialists who provide care to patients with complicated or complex medical problems. This new clinic and the new providers address this challenge. The new clinic is part of an innovative strategy to create and operate multispecialty clinics away from the main campus. UT Southwestern Medical Center has limited ability to expand its services to the community due to limitations on its current campus. Travel to the primary care and specialty clinics on the campus can be difficulty due to traffic and complicated directions. Not insignificantly, parking is often difficult and patients must pay for their parking. This new clinic will result in expanded primary care services closer to the communities and populations that want and need improved access to UT Southwestern primary care physicians and specialists. The clinic will be located near several major highways and roads. It is also accessible by the DART System bus and train lines.

By providing a new clinic at Hillcrest/Northwest Highway, UT Southwestern will be able to expand primary care and increase access to selected specialists, as well as primary care physicians, at a location that is easier to find and navigate. Increasing the number of primary care providers will reduce the time it takes patients to obtain appointments, which can reduce the time to needed diagnosis and treatment. Furthermore, creating additional access away from the UT Southwestern Medical Center campus will relieve campus congestion and improve access primary care physicians, as well as improving access to the comprehensive spectrum of specialists and diagnostic services on the campus. Effectively, the new clinic improves access to primary care and specialty care in both the new clinic and to the existing clinics on the UT Southwestern campus.

Community Needs Addressed:

The specific and unique community need identification numbers that this project addresses include the following:

- CN.3-Healthcare Capacity
- CN.9-Chronic Disease
- CN.12-Emergency Department Usage and Readmissions

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

Developing multispecialty clinics into the communities where our patients live is a new undertaking for UT Southwestern. The Medical Center has traditionally had a single campus focus where patients came for both primary care and specialty care. The Clinical Center will improve our ability to provide preventive services, basic primary care and specialty screening services to populations that want access to the quality of services offered by an academic medical center. Given the CNA stated shortage of access to primary care services, the ease of access to the Clinic will significantly improve our ability to meet the needs of the community.

Related Category 3 Outcome Measure(s):

OD-12 Primary Care and Primary Prevention
- IT-12.1 Breast Cancer Screening
- IT-12.3 Colorectal Cancer Screening
- IT-12.4 Pneumonia Vaccination Status of Older Adults

Reasons/rationale for selecting the outcome measures:

As part of a larger Chronic Disease Management strategy, monitoring indicators that will help detect problems and slow the progress of the disease are high priorities. The Community

Needs Assessment reported DFW Hospital Council data took note of the hospital admissions related to breast cancer and colorectal cancer. It also reported that admissions for diabetes sometimes had pneumonia as an accompanying complication. In order to provide these Primary Care Prevention outcomes, primary care providers must conduct regular basic health care examinations and help their patients develop a prevention-minded orientation to their health. The selected outcome measures are appropriate indicators of success in that effort.

Relationship to other Projects

This project relates to all of the other proposed projects in terms of improving access, capacity and performance across all primary care settings. The specific projects include:

126686802.1.1.2	Expand existing primary care capacity
126686802.1.7.1	Implement telemedicine program
126686802.2.1.1	Enhance/Expand Medical Homes

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

There are three other Category 1.1.1 projects in the RHP 9 Plan being proposed by Baylor Medical Center at Carrolton, CMC of Dallas, and Medical City Dallas Hospital. There are eight Category 1.1.2 projects seeking to expand existing primary care access. Furthermore, there are nine 2.1.1 projects that will develop or expand Patient-Centered Medical Homes. All of these efforts seek to provide better access and improved primary care prevention efforts.

The Anchor plans to develop and facilitate Learning Collaboratives in the Region with DFW Hospital Council. UT Southwestern will participate in the Collaborative(s) as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criterion rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using the criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). **This project's score for this criteria: 6**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population. **This project's score for this criteria: 3.85**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues. **This project's score for this criteria: 4.0**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person. **This project's score for this criteria: 5.0**

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability. **This project's score for this criteria: 7.0**

Total Valuation Score for this project: **4.8**

126686802.1.1	***PROJECT OPTION 1.1.1***	***PROJECT COMPONENT(S)*** *NONE REQUIRED*	*UT Southwestern Clinical Center:* Establishing a New Primary Care Community Outreach Center
The University of Texas Southwestern Medical Center			*126686802*
Related Category 3 Outcome Measures:	126686802.3.1 126686802.3.2 126686802.3.3	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening *3.* Pneumonia Vaccination Status of 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-1]: Establish additional clinics. **Metric 1.1 [P-1.1]:** Number of additional clinics **Baseline**: No previous free-standing off-campus UTSW clinic in Dallas. Documentation of detailed expansion plans. **Goal**: Add one (1) additional primary care clinic to be located in the Park Cities area, specifically Hillcrest Crossing. **Data Source**: Design and construction documents. Lease for new property. Rationale: The national, regional and local supply of primary care does not meet the demand for primary care services. Moreover, it is the goal of health care improvement to provider more preventive and primary care in order to keep individuals and families healthy and, thus, avoid more costly ER and inpatient care. **Milestone 1 Estimated Incentive Payment: $500,320**	**Milestone 5** [P-4]: Expand the hours of primary care clinic, including evening and/or weekend hours. **Metric 5.1 [P-4.1]:** Increased number of hours at primary care clinic over baseline. **Baseline**: DY2 will be the baseline period because this is a new clinic. **Goal:** 10% increase in number of hours (4 hours). **Data Source**: Clinic documentation of clinic hours Rationale: Expanded hours providers more choices for patients and and more allows for more patients to be seen. **Rationale**: During DY2, clinic will get established and build demand. During DY3, demand will warrant adding clinic hours in the evening or on the weekend. **Milestone 5 Estimated Incentive Payment: $732,551** **Milestone 6 [I -12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking	**Milestone 8 [P-4**]: Expand the hours of primary care clinic, including evening and/or weekend hours. **Metric 8.1 [P-4.1]:** Increased number of hours at primary care clinic over baseline. **Baseline:** DY2 operating schedule will be the baseline period. **Goal:** Additional 8 hours of evening and/or weekend on schedule from DY2 Schedule. **Data Source:** Clinic documentation of clinic hours **Milestone 8 Estimated Incentive Payment**: **$783,660** **Milestone 9 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 9.1 [I-12.1]:** Documentation of increased visits. **Baseline:** Total number of visits from previous year. **Goal**: Increase volume of visits by 30% over DY2.	**Milestone 11 [I -12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 11.1 [I-12.2]:** Documentation of unique visits or size of patient panels. **Baseline:** Baseline volume of unique patients from previous year. **Goal:** Increase unique patient volume by 20% over DY2. **Data Source:** EHR reports, other documentation **Rationale:** This measures the increased volume of new patients on the panel and is a method to assess the ability to increase capacity to provide care. **Milestone 11 Estimated Incentive Payment: $2,271,478**

126686802.1.1	***PROJECT OPTION 1.1.1***	***PROJECT COMPONENT(S)*** *NONE REQUIRED*	*UT Southwestern Clinical Center:* Establishing a New Primary Care Community Outreach Center	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measures:	126686802.3.1 126686802.3.2 126686802.3.3	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening *3.* Pneumonia Vaccination Status of 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 2 [P-5]: Train/hire additional primary care providers and staff, and increase the number of primary care clinics for existing providers. **Metric 2.1 [P5.1]:** Documentation of increased number of providers and staff. **Baseline**: This is a new clinic, therefore, the baseline is zero (0) UTSW providers and staff in an off-campus multispecialty clinic. **Goal**: Add at least 3 primary care physicians and 9 support staff. **Data Source**: New Primary Care schedules, Faculty Practice Plan and Human Resources hiring summaries and other related documents. **Rationale**: Each new Primary Care Physician will build to a panel of approx. 2,000 patients, with between 4,000 and 5,000 visits per year. **Milestone 2 Estimated Incentive Payment: $500,320** **Milestone 3 [I-12]:** Increase primary care clinic volume of visits and evidence	services. **Metric 6.1 [I-12.1]:** Documentation of increased unique visits. **Baseline:** Total number of visits from DY2. **Goal**: Increase volume visits by 20% over previous project year. **Data Source:** EHR reports, other documentation **Rationale:** This measures the increased volume of visits and is a method to assess the ability to increase capacity to provide care. **Milestone 6 Estimated Incentive Payment: $732,552** **Milestone 7 [I -12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 7.1 [I-12.2]:** Documentation of unique visits or size of patient panels. **Baseline:** Baseline volume of unique patients from DY2. **Goal:** Increase panel size by 10% over previous year. **Data Source:** EHR reports, other	**Data Source:** EHR reports, other documentation **Rationale:** This measures the increased volume of visits and is a method to assess the ability to increase capacity to provide care. **Milestone 9 Estimated Incentive Payment**: **$783,660** **Milestone 10 [I -12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 10.1 [I-12.2]:** Documentation of unique visits or size of patient panels. **Baseline:** Baseline volume of unique patients from DY2. **Goal**: Increase unique patient volume by 15% over DY2. **Data Source:** EHR reports, other documentation **Rationale:** This measures the increased volume of new patients on the panel and is a method to assess the ability to	

126686802.1.1	***PROJECT OPTION 1.1.1***	***PROJECT COMPONENT(S)*** *NONE REQUIRED*	*UT Southwestern Clinical Center:* Establishing a New Primary Care Community Outreach Center	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measures:	126686802.3.1 126686802.3.2 126686802.3.3	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening *3.* Pneumonia Vaccination Status of 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)**
of improved access for patients seeking services. **Metric 3.1 [I-12.2]:** Documentation of unique visits or size of patient panels. **Baseline:** Baseline is zero because this is a new clinic. **Goal**: 2,500 patient visits in what remains of the project year after clinic opening. **Data Source:** EHR reports, other documentation **Rationale:** This measures the increased volume of visits and is a method to assess the ability to increase capacity to provide care. New clinics and physician practices take time to build volume. **Milestone 3 Estimated Incentive Payment**: **$500,321** **Milestone 4 [I -12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 4.1 [I-12.1]:** Documentation of increased unique visits. **Baseline:** Because this is a new clinic, the baseline is zero. **Data Source:** EHR reports, other	documentation **Rationale:** This measures the increased volume of patients on the panel and is a method to assess the ability to increase capacity to provide care. **Milestone 7 Estimated Incentive Payment: $732,552**	increase capacity to provide care. **Milestone 10 Estimated Incentive Payment**: **$783,660**	

126686802.1.1	***PROJECT OPTION 1.1.1***	***PROJECT COMPONENT(S)*** *NONE REQUIRED*	*UT Southwestern Clinical Center:* Establishing a New Primary Care Community Outreach Center	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measures:	126686802.3.1 126686802.3.2 126686802.3.3	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening *3.* Pneumonia Vaccination Status of 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)**
documentation **Goal**: 800 unique patients during remainder of project year. **Rationale:** This measures the increased volume of visits and is a method to assess the ability to increase capacity to provide care. **Milestone 4 Estimated Incentive Payment**: **$500,321**			
Year 2 Estimated Milestone Bundle Amount**: $2,001,282**	Year 3 Estimated Milestone Bundle Amount: **$2,197,655**	Year 4 Estimated Milestone Bundle Amount: **$2,350,980**	Year 5 Estimated Milestone Bundle Amount: **$2,271,478**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***: $8,821,395**			

***Project Option 1.1.2* - Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics**

RHP Project Identification Number: 126686802.1.2
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern") Faculty Practice Plan/126686802

Summary Information:
Summary Description: The UTSCAP Primary Care Network (the "Network") is designed to expand access to primary care resources in RHP 9 and integrate community-based primary care physicians and UTSW faculty physicians. The Network is actively recruiting community-based primary care physicians to join UT Southwestern. The goal of the Network is to expand physician acceptance of all payor sources, improve capacity, improve access, and improve quality through use of a common EMR and numerous other quality initiatives . In addition, this project will create a nurse advise line for all patients of the UTSCAP Network.

Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 40 hospital-based and ambulatory-based clinics on its Dallas campus. UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas.

Intervention(s): The project will expand the primary care capacity in RHP 9: [1] by having physicians who don't currently avail themselves to certain payor segments (i.e. Medicaid) agree to open their panels to these patients; [2] by Network physicians agreeing to after-hours care and/or weekend hours; [3] by Network physicians adding new partners out of residency; and [4] by optimizing throuput. Project also adds primary care resources through new nurse advise line.

Need for the Project: Primary care capacity in our Region is limited, siloed and operating inefficiently. Finally, RHP 9 identified a lack of primary care capacity, coupled with high rates of ED usage and readmissions, as areas of great concern for our Region.

Target Population: The target population is the 2.416 million people living in Dallas County, 25.4% of whom are uninsured. Dallas County also includes over 413,000 Medicaid enrollees.

Category 1 or 2 Expected Patient Benefits: This project seeks (1) to expand access to primary care resources in the Region, 2) to increase the volume of primary care visits under the UTSCAP Network and (2) to increase the number of Network patients served by our new nurse advice line. Through this Network, our expectation is that UTSW will substantially add to the number of patients in RHP 9 that will have access to high quality, integrated care that has historically been unavailable. We anticipate adding 126 or more primary care physicians to this Network. UTSW expects that by DY5 approximately 44,000 Medicaid/low income patients per year would benefit from this Network expansion resulting in 111,000 office visits, 178,000 patient contacts,

and access to additional primary care resources through the new Nurse Call line. Adding and/or expanding practices will increase office hours, staff hours, and office space for Medicaid patients.

Category 3 Outcome Measures: IT-12.1 Breast Cancer Screening, IT-12.3 Colorectal Cancer Screening, and IT-12.4 Pneumonia Vaccination Status of Older Adults

Project Description

UT Southwestern proposes to expand the primary care capacity in the UTSCAP Primary Care Network to better accommodate the needs of RHP 9 patients and the community.

The UTSCAP Primary Care Network (the "Network") is designed to integrate community-based primary care physicians and the faculty physicians of UT Southwestern Medical Center ("UT Southwestern"). The Network is in an early stage of development and growth and is actively recruiting community-based primary care physicians and their practices to join UT Southwestern faculty physicians. The ultimate goal of the Network is delivering patient care at the highest level of quality by the most cost-effective means, achieved through the clinical integration of Network physicians. Such outcomes are good for patients, payors, physicians and the community. The specific short and long-term objectives for the Network include:

- Expanding access to primary care resources for RHP 9 patient population.
- Expanding, strengthening and implementing a clinically integrated network;
- Creating and implementing a quality care model that will most efficiently utilize finite primary care resources for patients of RHP 9.
- Developing an infrastructure for effective care coordination of Network patients;
- Enhancing and continually developing a clinically integrated organizational structure in preparation of health care reform and value-based reimbursement; and
- Advancing the use of technology to improve health care and reduce medical errors.

This project will improve access to primary care services by creating a robust Network of efficient, quality primary care physicians for RHP 9 patients. Specifically, the Network intends to expand primary care capacity and enhance both efficiencies and quality performance by:

- Having physicians who don't currently avail themselves to certain payor segments (i.e. Medicaid) agree to open their panels to these patients. Therefore, although some may be existing community PCP resources, we will be expanding access to primary care resources for our targeted populations;
- Working with Network physicians to participate in after-hours care programs and/or weekend clinic availability along with additional primary care resources via the Nurse Call line;
- Adding new physicians to the Network and enabling patient panel expansion;
- Facilitating Network physicians adding new partners out of residency or outside the RHP 9;
- Requiring the use of an EMR for all network providers to help optimize throughput; and
- Requiring providers to participate in quality enhancement programs of Network (i.e. quality standards, protocol adherence, progressing towards PCMH principles, etc.).

As community-based primary care physicians join the Network, they will no longer be practicing in "isolation". Through clinical integration with UT Southwestern faculty physicians, these community-based primary care physicians will engage in the continual development and implementation of clinical "best practice" protocols for the diseases treated by all Network physicians that are also responsible for the largest percentage of medical costs, such as diabetes and hypertension. In addition, the project will also expand access to primary care services at the point of need by providing Network patients' access to a 24/7 nurse advice line. By developing a nurse triage line capability, we intend to help patients make better decision regarding whether an office visit or other care is necessary, expanding access to primary care services while potentially freeing up PCP office capacity. Overall, the Network is aimed at expanding access to primary care by adding PCP capacity and through the efficient and effective delivery of quality primary care.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relations to Regional Goals:

The project goals are as follows:

- Expanding access to primary care resources for RHP 9 patient population;
- Create an environment within the Network whereby community-based primary care physicians who don't currently treat certain patients (i.e. Medicaid), open their panel to a broader patient population;
- Expand primary care capacity through efficiencies and access to a shared Network population management infrastructure to address the primary care needs of our patient population;
- Implement a nurse advice line accessible to patients throughout the Network to enhance patient access to the right care, at the right time, in the right setting, and by the right provider;
- Offer clinical expertise and management support for new and existing primary care physicians that enable them to efficiently care for more patients.

All of these goals are aimed at patients receiving the right care, at the right time, in the right setting, and by the right provider

This project also meets the following regional goals:

RHP 9, and the Nation, has a primary care provider and capacity issue. This project aims to address increasing access to primary care and providing high quality, comprehensive care to patients in a less costly setting—an integrated primary care Network. Emergency Department

utilization is high in RHP 9 and by providing more patients with the primary care they need, a regional goal is to keep patients from unnecessarily using the emergency departments and urgent care centers as a means to receive basic care.

Challenges

One of the major challenges for RHP 9 and the healthcare market in general is a shortage of primary care physician capacity. This problem is likely to worsen in a healthcare reform environment where more people are expected to have insurance coverage. The primary ingredient in the cost reduction recipe is for more patients to be seen in a primary care setting in lieu of specialty offices, ER, urgent care, or inpatient facilities. Another major impediment in RHP 9 to enhanced productivity in primary care settings is the extensive number of solo to very small primary care practices that exists within our community.

Finally, many primary care physicians don't treat all types of insured patients, because the economics associated with some payor sources are a major challenge to the viability of practices. These are only a few of the many challenges facing the effort to expand primary care access in RHP 9. To address these challenges UT Southwestern intends to hasten the "virtual" consolidation of these private practices through their membership in the Network and into population management units with access to shared resources enabling the expansion of primary care access to RHP 9 patient populations. By creating a Network that incents broader payor participation and facilitates caring for these patients more efficiently, UT Southwestern will enable expanded primary care capacity, ensuring more patients have access to high quality, cost effective primary care.

5-Year expected Outcomes for Provider and Patients:

The 5-year expected outcome of this initiative will be enhanced access and quality for patients seeking primary care, as well as the Network physicians' ability to measure, monitor, and provide increased services to the patient population of RHP 9. Through this Network, our expectation is that UTSW will substantially add to the number of patients in RHP 9 that will have access to high quality, integrated care that has historically been unavailable. We anticipate adding 126 or more primary care physicians to this Network. UTSW expects that by DY5 approximately 44,000 Medicaid/low income patients per year would benefit from this Network expansion resulting in 111,000 office visits, 178,000 patient contacts, and access to a new Nurse Call line. Adding and/or expanding practices in the Network should result in 68,000 office hours, 238,000 office staff hours, and around 21,000 square feet of office space available to Medicaid patients. Overall, by DY5 UTSW expects approximately 277,000 patients per year will benefit from this Network expansion, resulting in 693,000 office visits, 1,100,000 patient contacts, and access to a new Nurse Call line. In total, adding and/or expanding practices in the Network should result in 242,000 office hours, 846,000 office staff hours, and around 151,000 square feet of office space. Due to the impact of health reform, the economy, patient migration, etc., it's impossible to predict how many new unique vs. existing market patients will utilize the Network. However, by adding primary care access through opening provider panels, increasing efficiency to allow expanded panel sizes, adding new physicians, and introducing

new primary care resources (e.g. Nurse Call line), UTSW will expand primary care access to patients of RHP 9.

Starting Point/Baseline

The development of a clinically integrated Network of community-based, primary care physicians and UT Southwestern faculty physicians supported by a robust population management infrastructure does not currently exist. Thus, the starting point for this project (the one-year period prior to December 1, 2011) is as follows. UT Southwestern has three (3) primary care clinics: the Aston Clinic, the Multi-Specialty Clinic and the Family Practice Clinic. The community-based, primary care clinics that are members of the UTSCAP Network totaled three (3). Neither the Network nor UT Southwestern has implemented a nurse advice line to assist patients with information and advice at their point of need.

Rationale

More often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly care and sicker patients.

UT Southwestern physician services are directly impacted by the negative outcomes created by inadequate access to efficient, quality primary care services. By enhancing access points into an integrated primary care Network throughout the community, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes and appropriate utilization and reduced cost of health care services delivered.

For these reasons, UT Southwestern chose this project to address the shortage of primary care physicians willing to treat all patients under the current environment. We believe the problem is likely to worsen in the healthcare reform environment. If the objective is to improve quality, reduce cost, and improve outcomes, expanding access to primary care services is going to be a critical part of the solution. The more care that can be pushed towards primary care, the better we can decompress ER's, specialty clinics, and facilities.

In the RHP 9 market today, there has been little attention or resources provided to creatively engage independent, community-based primary care practices in a population management solution for all populations. For a number of the reasons outline above, providers and health systems have been focused on developing business strategies around commercial populations where investments of finite resources have a more reasonable chance of a return on the investment.

Project components, milestones and metrics:

Through this project, we propose to meet all the required project components:

- Expand primary care clinic space. The integration and expansion of community-based primary care physicians into the Network, along with the efficiency goals of the Network will create increased clinic space throughout the Network.

- Expand primary care clinic hours. The integration and expansion of community-based primary care physicians in the Network will include clinics with expanded/after-hours care.

- Expand primary care clinic staffing. The integration and expansion of community-based primary care clinics into the Network, will result in an increase in primary care clinic staffing within the Network devoted and trained to delivery efficient, quality health care services.

To accomplish UT Southwestern's ultimate goal to expand primary care capacity to accommodate RHP 9 patients receiving the right care, at the right time, in the right setting, and by the right provider, we must focus on key areas. Thus, UT Southwestern will expand primary care capacity and access through the following selected milestones for this project:

- Establish additional/ expand existing/ relocate primary care clinics;

- Implement a nurse triage software system to assist nurses in determining the acuity of patients;

- Establish a nurse advice line; and

- Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

Community Needs Addressed

The specific and unique community need identification numbers that this project addresses include the following:

- CN.2-Regional Healthcare Infrastructure and Patient Migration Patterns

- CN.3- Healthcare Capacity

- CN.4-Primary Care and Pediatrics

- CN.12-ED Usage and Readmissions

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

This project represents a new reform initiative for UT Southwestern. UT Southwestern in collaboration with community primary care providers will support the delivery of quality, evidence-based, efficient primary care through this clinically integrated Network. This solution will be an enhancement over the existing, "silo" delivery system by addressing the challenges highlighted above, and embracing the challenges of all patient populations. By incorporating the needs of these populations in the development of a population management infrastructure, the system for delivering primary care will improve. UT Southwestern will work independently, with our campus partners, and with community partners to establish clinics capable of delivering high quality primary care and making appropriate referrals to specialists and facilities.

Related Category 3 Outcome Measure(s)

OD-12 Primary Care and Primary Prevention Outcomes:

- IT-12.1 Breast Cancer Screening (HEDIS 2012)
- IT-12.3 Colorectal Cancer Screening (HEDIS 2012)
- IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012)

Reasons/rationale for selecting the outcome measures:

Our expansion of existing primary care capacity in the UTSCAP network is aimed at improving the delivery of care, at the right time, in the right setting. We selected the above outcomes because expanding access to primary care services should result in the increased incidence of preventative services actually delivered to patients. We subscribe to the theory that screening programs should lead to a cost-effective reduction in disease burden. UT Southwestern will focus on this outcome for all our attributed patients, irrespective of their socioeconomic status. As a result, we believe focusing on these outcomes will make a measurable difference for individuals in RHP 9 at all income levels.

Relationship to other Projects:

The success of this initiative is highly dependent on the implementation of the following other projects proposed by UT Southwestern:

- *126686802.2.1.1—Expanding the Medical Home Model in the UTSCAP Primary Care Network: 126686802.1.1.4—Implement a Quality Incentive Program for Network Primary Care Providers:*
- *126686802.1.10.2—Implement UT Southwestern Population Management Infrastructure Development*
- *126686802.2.9.1—Implement/Expand Care Coordination Programs:*

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

Other projects that focus on expanding primary care are: 121790303.1.1, 121776204.1.1, 195018001.1.1 139485012.1.1, 138910807.1.1, 138910807.1.2, 020943901.1.3, 127295703.1.1, 127295703.1.2, 020908201.1.1.

The providers of these projects have confirmed that: 1) we each serve distinct geographical areas and/or 2) populations of the underserved.

Plan for Learning Collaborative: The Anchor plans to develop and facilitate Learning Collaboratives in the Region with DFW Hospital Council. UT Southwestern will participate in the Collaborative(s) as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). **This project's score for this criteria: 4.5 X 2 = 9**
2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population. **This project's score for this criteria: 3.5 X 2 = 7**
3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues. **This project's score for this criteria: 4.5 X 2 = 9**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person. **This project's score for this criteria: 3.8 X 2 = 7.6**
5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability. **This project's score for this criteria: 4 X 2 = 8**

Total Valuation Score for this project: **8.2.** These values are provided for in the table below and are allocated equally amongst the milestones.

126686802.1.2	***PROJECT OPTION 1.1.2***	***PROJECT COMPONENT(S) 1.1.2(A-C)***	***Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics***	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measure(s):	126686802.3.4 126686802.3.5 126686802.3.6	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening 3. Pneumonia Vaccination Status of 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-1]: Establish additional/ expand existing/ relocate primary care clinics. Metric 1.1 [P-1.1]: Number of additional clinics or expanded hours or space. Baseline: 6 Clinics Goal: Increase in number of Network physicians by 30. Data Source: Contracts, credentialing records, or other documentation of new community-based, primary care clinics joining the UTSCAP Network. **Milestone 1 Estimated Incentive Payment: $850,545** **Milestone 2** [I-12]: Establish the baseline of the UTSCAP Network's primary care clinic volume of visits and type. Metric 2.1 [I-12.1]: Network volume of visits and type. Baseline: Unknown Goal: Documentation of the Network's baseline for primary	**Milestone 5** [P-6]: Implement a nurse triage software system to assist nurses in determining the acuity of patients. Metric 5.1 [P-6.1]: Documentation of the availability and utilization of a nurse triage system. Such documentation of the triage system shall be detailed to include the specific components (functionality) of the system. Baseline: No available system Goal: Documentation of the availability and utilization of nurse triage system. Data Source: Documentation of vendor agreement and staff training in use of system. **Milestone 5 Estimated Incentive Payment: $467,002** **Milestone 6 [P-1]:** Establish additional/ expand existing/ relocate primary care clinics. **Metric 6.1 [P-1.1]:** Number of additional clinics or expanded hours or space. **Baseline:** 36 physicians in UTSCAP		**Milestone 13** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 13.1 [I-12.1]: Documentation of increased number of visits. Baseline: Number of primary care visits established in Milestone 2 of DY2 plus 5% increase.. Goal: 10% Increase over Baseline. Data Source: Network data and EHR/PMS data.. **Milestone 13 Estimated Incentive Payment: $499,583** **Milestone 14** [I-14]: Increase the number of patients served and questions addressed on the nurse advice line. Demonstrate improvement over prior reporting year. Metric 14.1 [I-14.1]: Number of patients served by the nurse advice line. Baseline: DY3 patients served by the nurse advice line. Goal: 5% increase over baseline.	**Milestone 21** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 21.1 [I-12.1]: Documentation of increased number of visits. Baseline: Number of primary care visits established in Milestone 2 of DY2 plus 15% increase. Goal: 5% Increase over Baseline. Data Source: Network data and EHR/PMS data.. **Milestone 21 Estimated Incentive Payment: $551,644** **Milestone 22** [I-14]: Increase the number of patients served and questions addressed on the nurse advice line. Demonstrate improvement over prior reporting year. Metric 22.1 [I-14.1]: Number of patients served by the nurse advice line. Baseline: DY4 patients served by the nurse advice line. Goal: 3% increase over baseline.

126686802.1.2	***PROJECT OPTION 1.1.2***	***PROJECT COMPONENT(S) 1.1.2(A-C)***	***Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics***	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measure(s):	126686802.3.4 126686802.3.5 126686802.3.6	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening 3. Pneumonia Vaccination Status of 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)**
care clinic volume of visits and type. Data Source: Network data and EHR/PMS data. **Milestone 2 Estimated Incentive Payment: $850,545** **Milestone 3** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours. Metric 3.1 [P-4.1]: Increased number of hours at primary care clinic over baseline. Baseline: Zero (0) evening and/or weekend hours. Goal: 2 UTSCAP Network clinics with evening and/or weekend hours. Data Source: Clinic schedule documentation. **Milestone 3 Estimated Incentive Payment: $850,545** **Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.	Network. **Goal:** Add 30 physicians. Data Source: Contracts, credentialing records, or other documentation of new community-based, primary care physicians/clinics joining the UTSCAP Network. **Milestone 6 Estimated Incentive Payment: $467,002** **Milestone 7** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 7.1 [I-12.1]: Documentation of increased number of visits. Baseline: Number of primary care visits established in Milestone 2 of DY2. Goal: 5% Increase over Baseline. Data Source: Network data and EHR/PMS data.. **Milestone 7 Estimated Incentive Payment: $467,002** **Milestone 8** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend		Data Source: Call center data and care coordinator call statistics. **Milestone 14 Estimated Incentive Payment: $499,583** **Milestone 15** [P-1]: Establish additional/ expand existing/ relocate primary care clinics. Metric 15.1 [P-1.1]: Number of additional clinics or expanded hours or space. Baseline: 66 physicians in UTSCAP Network. Goal: Add 30 physicians. Data Source: Contracts, credentialing records, or other documentation of new community-based, primary care clinics joining the UTSCAP Network. **Milestone 15 Estimated Incentive Payment: $499,583** **Milestone 16** [P-6]: Implement a nurse triage software system to assist nurses in determining the acuity of patients. Metric 16.1 [P-6.1]: Documentation of the availability and utilization of a nurse triage system. Such	Data Source: Call center data and care coordinator call statistics. **Milestone 22 Estimated Incentive Payment: $551,644** **Milestone 23** [P-1]: Establish additional/ expand existing/ relocate primary care clinics. Metric 23.1 [P-1.1]: Number of additional clinics or expanded hours or space. Baseline: 96 physicians in UTSCAP Network. Goal: Add 30 physicians. Data Source: Contracts, credentialing records, or other documentation of new community-based, primary care clinics joining the UTSCAP Network. **Milestone 23 Estimated Incentive Payment: $551,644** **Milestone 24** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours.

126686802.1.2	***PROJECT OPTION*** ***1.1.2***	***PROJECT COMPONENT(S)*** ***1.1.2(A-C)***	***Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics***	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measure(s):	126686802.3.4 126686802.3.5 126686802.3.6	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening 3. Pneumonia Vaccination Status of 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)**
Metric 4.1 [I -12.2]: Documentation of increased number of unique patients, or size of patient panels. Baseline: Unknown - TBD. Goal: See 100 new unique patients within network during DY2. Data Source: Registry, EHR, claims or other Performing Provider source. **Milestone 4 Estimated Incentive Payment: $850,545**	hours. Metric 8.1 [P-4.1]: Increased number of hours at primary care clinic over baseline. Baseline: 2 clinics with evening and/or weekend hours. Goal: Add 5 UTSCAP Network clinics with evening and/or weekend hours. Data Source: Clinic schedule documentation. **Milestone 8 Estimated Incentive Payment: $467,002** **Milestone 9** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 9.1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. **Baseline: Zero (0) hired primary care providers.** **Goal: Hire 2 new primary care physician and add to UTSCAP Network.**		documentation of the triage system shall be detailed to include the specific components (functionality) of the system. Baseline: Calls received during DY3. Goal: 5% increase in calls over baseline. Data Source: Documentation of vendor agreement and staff training in use of system. **Milestone 16 Estimated Incentive Payment: $499,583** **Milestone 17** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours. Metric 17.1 [P-4.1]: Increased number of hours at primary care clinic over baseline. Baseline: 7 clinics with evening and/or weekend hours. Goal: Add 5 UTSCAP Network clinics with evening and/or weekend hours. Data Source: Clinic schedule documentation. **Milestone 17 Estimated Incentive**	Metric 24.1 [P-4.1]: Increased number of hours at primary care clinic over baseline. Baseline: 12 clinics with evening and/or weekend hours. Goal: Add 3 UTSCAP Network clinics with evening and/or weekend hours. Data Source: Clinic schedule documentation. **Milestone 24 Estimated Incentive Payment: $551,644** **Milestone 25** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 25.1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline: 4 hired primary care providers. Goal: Hire 1 new primary care physician and add to UTSCAP Network. Data Source: Employment contract.

126686802.1.2	*PROJECT OPTION 1.1.2*	*PROJECT COMPONENT(S) 1.1.2(A-C)*	***Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics***	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measure(s):	126686802.3.4 126686802.3.5 126686802.3.6	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening 3. Pneumonia Vaccination Status of 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)**
	Data Source: Employment contract. **Milestone 9 Estimated Incentive Payment: $467,002** **Milestone 10** [P-7]: Establish nurse advice line. Metric 10.1 [P-7.1]: Documentation of nurse advice line. Baseline: No available nurse line Goal: Documentation of implementation of a nurse advice line. Data Source: Documentation of nurse line implementation, operating hours, call logs, triage algorithms, and triage policies. **Milestone 10Estimated Incentive Payment: $467,002** **Milestone 11** [I-14]: Increase the number of patients served and questions addressed on the nurse advice line. Demonstrate improvement over prior reporting year.		**Payment: $499,583** **Milestone 18** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 18.1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline: 2 hired primary care provider. Goal: Hire 2 new primary care physician and add to UTSCAP Network. Data Source: Employment contract. **Milestone 18 Estimated Incentive Payment: $499,583** **Milestone 19** [I-13]: Enhanced capacity to provide urgent care services in the primary care setting. Metric 19.1 [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	**Milestone 25 Estimated Incentive Payment: $551,644** **Milestone 26** [I-13]: Enhanced capacity to provide urgent care services in the primary care setting. Metric 26.1 [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. Baseline: Number of urgent care primary care visits recorded in DY4. Goal: 2% increase over Baseline. Data Source: Network data and EHR/PMS data. **Milestone 26 Estimated Incentive Payment: $551,644** **Milestone 27** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 27.1.1 [I -12.2]: Documentation of increased number of unique patients, or size of patient

126686802.1.2	***PROJECT OPTION 1.1.2***	***PROJECT COMPONENT(S) 1.1.2(A-C)***	***Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics***	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measure(s):	126686802.3.4 126686802.3.5 126686802.3.6	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening 3. Pneumonia Vaccination Status of 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)**
	Metric 11.1 [I-14.1]: Number of patients served by the nurse advice line. Baseline: Zero (0) patients served by the nurse advice line as the UTSCAP Network did not have a nurse advice line. Goal: Average of 100 calls per month after Nurse Advice Line implemented. Data Source: Call center data and care coordinator call statistics. **Milestone 11 Estimated Incentive Payment: $467,001** **Milestone 12** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 12.1 [I -12.2]: Documentation of increased number of unique patients, or size of patient panels. Baseline: DY2 patient base. Goal: See 200 new unique patients within network during DY3. Data Source: Registry, EHR, claims or other Performing Provider		request. Baseline: Number of urgent care primary care visits established in Milestone 2 of DY2. Goal: 5% increase over baseline. Data Source: Network data and EHR/PMS data. **Milestone 19 Estimated Incentive Payment: $499,583** **Milestone 20** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 20.1 [I -12.2]: Documentation of increased number of unique patients, or size of patient panels. Baseline: DY3 patient base. Goal: See 200 new unique patients within network during DY4. Data Source: Registry, EHR, claims or other Performing Provider source. **Milestone 20 Estimated Incentive Payment: $499,583**	panels. Baseline: DY4 patient base. Goal: See 200 new unique patients within network during DY4. Data Source: Registry, EHR, claims or other Performing Provider source. **Milestone 27 Estimated Incentive Payment: $551,644**

126686802.1.2	***PROJECT OPTION*** ***1.1.2***	***PROJECT COMPONENT(S)*** ***1.1.2(A-C)***	***Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics***	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measure(s):	126686802.3.4 126686802.3.5 126686802.3.6	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening 3. Pneumonia Vaccination Status of 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)**
	source. **Milestone 12 Estimated Incentive Payment: $467,001**			
Year 2 Estimated Milestone Bundle Amount: **$3,402,180**	Year 3 Estimated Milestone Bundle Amount: **$3,736,014**		Year 4 Estimated Milestone Bundle Amount: **$3,996,666**	Year 5 Estimated Milestone Bundle Amount: **$3,861,513**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: **$14,996,373**				

Project Option 1.1.4 - Implement a Quality Incentive Program for UTSCAP Network Primary Care Physicians

Unique Project ID: 126686802.1.3
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW") Faculty Practice Plan/126686802

Summary Information

Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 40 hospital-based and ambulatory-based clinics on its Dallas campus. UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, 24% of UTSW patient charges were attributed to Medicaid patients across Parkland, Children's and UT Southwestern.

Intervention(s): This project will expand primary care capacity in the Region while simultaneously providing evidence-based care by developing and implementing a quality incentive program to improve the delivery of safe, quality primary care services in our community.

Need for the Project: Primary care capacity in our Region is limited, siloed and operating inefficiently. RHP 9 identified a lack of primary care capacity, coupled with high rates of ED usage and readmissions, as areas of great concern for our Region. The Community Needs Assessment for RHP 9 discusses the objective of implementing novel approaches to quality improvement for addressing the health needs of our community. It is not enough to expand the primary care capacity in our community. We must also improve the delivery of quality primary care services. Without the delivery of quality primary care, the occurrence of high emergency department utilization for ambulatory conditions and other inefficiencies in our Region will continue.

Target Population: The target population is all UTSCAP Network patients with an emphasis on Medicaid patients. There are 2.416 million people living in Dallas County, 25.4% of who are uninsured. Dallas County also includes over 413,000 Medicaid enrollees.

Category 1 or 2 Expected Patient Benefits: This project seeks to expand access to primary care resources in the Region, while simultaneously incenting high quality, evidence-based care. By DY5, UT Southwestern expects the majority of UTSCAP Network physicians will meet established "gateway" requirements and metrics - see Appendix A, B, and C. We expect patients will benefit from having enhanced access to primary care services and care givers who adhere to evidence-based practices. Results found in the literature of pay-for-performance are included in Appendix D.

We anticipate adding 126 or more primary care physicians to this Network. UTSW expects that by DY5 approximately 44,000 Medicaid/low income patients per year would benefit from this Network expansion resulting in 111,000 office visits, 178,000 patient contacts, and access to a new Nurse Call line.

Category 3 Outcome Measures:

- IT-12.1 Breast Cancer Screening.
- IT-12.3 Colorectal Cancer Screening
- IT-12.4 Pneumonia Vaccination Status of Older Adults

Project Description

UT Southwestern proposes to develop and implement a quality incentive program to improve the delivery of safe, quality primary care services in our community.

The UTSCAP Primary Care Network (the "Network") is designed to integrate community-based primary care physicians and the faculty physicians of UT Southwestern Medical Center ("UT Southwestern"). The Network is in an early stage of development and growth and is actively recruiting community-based primary care physicians and their practices to join UT Southwestern faculty physicians. The ultimate goal of the Network is delivering patient care at the highest level of quality by the most cost-effective means, achieved through the clinical integration of Network physicians. Such outcomes are good for patients, payors, physicians and the community. The specific short and long-term objectives for the Network include:

- Expanding access to primary care resources for RHP 9 patient population (emphasis on Medicaid), while aligning incentives for quality outcome performance.
- Develop a quality incentive program for primary care providers focused on access and quality outcomes;
- Develop the infrastructure to effectively measure and monitor primary care provider adherence to established evidence-based protocols;
- Implement the quality incentive program to RHP 9 primary care physicians clinically integrated with UT Southwestern; and
- Monitor participating providers on a regular basis to ensure evidence-based, quality care is being provided.

This project is designed not only to expand access to primary care, but to increase the quality of primary care delivered to Network patients. It is also intended to create an environment whereby primary care physicians who don't currently treat certain patients (i.e. Medicaid, begin seeing all populations as a viable part of a broader patient population management program. This quality incentive program is expected to motivate community-based primary care

physicians affiliated with the UT Southwestern to become Medicaid providers, since only Network physicians who are Medicaid providers are eligible for the quality incentive program. We believe this quality incentive program will be good for the physicians, the community and the Medicaid program.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relations to Regional Goals:

The primary goal of this project is to expand primary care capacity and increase the *quality* of primary care through an incentive program rewarding Network physicians for the investments in and accomplishments made in delivering evidence-based quality care to Network patients. UT Southwestern will achieve this primary goal by attaining the following project goals:

- Developing a pay-for-performance program that is attractive to primary care providers because it incents quality and defrays the cost associated with participating.
- Establish Utilization and Quality Improvement Committees that includes representation of UTSCAP Network physicians—both UTSW faculty primary care physicians and affiliated community-based primary care physicians.
- Review nationally recognized quality measures and establish a menu of quality measures for the Incentive Program.
- Create an electronic "Network Clinical Protocol Library" that is readily available to Network physicians.
- Measure and report the menu of quality measures to Network primary care physicians
- Improve adherence to clinical protocols and achieve measureable, improved quality within the Network.
- Require providers submit electronic data to CDR to facilitate monitoring protocol adherence
- Require providers install an EMR.

This project also meets the following regional goals:

The project aims to expand Region primary care resources and deliver *quality*, comprehensive care to patients in a less costly setting—an integrated primary care Network. Emergency Department utilization is high in RHP 9 and by providing patients with the quality primary care

they need, when they need it, the regional goal can be attained to keep patients from unnecessarily using the emergency departments and urgent care centers as a means to receive basic care.

Challenges

The specific challenge facing many primary care providers is the cost associated with investing in quality programs that are simply not reimbursed in most of today's contractual arrangements. While new models are emerging to defray the costs associated with providers delivering services that lead to quality outcomes, these arrangements are either greatly fragmented or non-existent in RHP 9 today. RHP 9 needs to address this challenge by developing a program that encourages providers to make the investments necessary to measure, monitor, and improve evidence based performance that is applicable to all patient populations in RHP 9. Another major impediment in RHP 9 to enhanced quality in primary care settings is the number of solo to very small primary care practices that exists within our community. Finally, many of these primary care physicians don't treat all patients because the economics associated with some payor sources (i.e. Medicaid), are a major challenge for practices.

To address these challenges UT Southwestern intends to develop a robust program of measuring and monitoring provider performance within the Network against various nationally recognized quality measures/benchmarks for Network patients. UT Southwestern believes providers will make the quality care investments necessary if they have the opportunity to be compensated for meeting quality measures/benchmarks.

5-Year expected Outcomes for Providers and Patients:

The 5-year expected outcome of this project will be expanded primary care access and the development and implementation of a quality incentive program that financially rewards physicians who provide high quality patient care to all patient populations in RHP 9. To qualify for program participation, primary care physicians must participate in the Medicaid program. We anticipate adding 126 or more primary care physicians to the Network and that 25%-40% will participate in this quality incentive program. UTSW expects that by DY5 approximately 44,000 Medicaid/low income patients per year would benefit from this Network expansion resulting in 111,000 office visits, 178,000 patient contacts, and access to a new Nurse Call line. Due to the impact of health reform, the economy, patient migration, etc, etc.., it's impossible to predict how many new unique vs existing market patients will be impacted by this program. However, by adding primary care access through opening provider panels, increasing efficiency to allow expanded panel sizes, emphasizing evidence based quality metrics, rewarding primary care physicians for their quality results, and introducing new primary care resources (e.g. Nurse Call line), UTSW will expand primary care access to patients of RHP 9. This will lead to UT Southwestern simultaneously expanding access to primary care services to all populations while making the investments necessary to ensure and demonstrate the quality of those services being delivered. UT Southwestern feels the impact of this initiative in the overall success of UT Southwestern's efforts to expand primary care access in RHP 9 will be vital. Patients will

witness the significance of this project by the impact it will have on their ability to gain access to *quality* primary care services on a timely basis.

UT Southwestern believes this type of program has been successful in other parts of the country. For example, in 2005, Geisinger Health Plan introduced the web-based Physician Quality Summary, which compares the performance of contracted primary care practice sites on nine clinical quality and patient service metrics using a three-star rating system. Practices that achieve three-star rankings are eligible for financial rewards. From 2005 to 2007, Geisinger primary care clinic sites increased their three-star rankings threefold (from 22% to 69% of their rankings) as a result of improvements driven by systems such as patient registries and automated preventive care notifications (Exhibit 7). There was little change in rankings of non-Geisinger-contracted sites during this time, with their three-star rankings remaining at about 6 percent to 7 percent. Find the full case study and additional supporting information in Appendix D.

Starting Point/Baseline

UT Southwestern is actively engaged in creating a culture of patient safety and quality through educational means; this project will be the next step in the transformation towards a quality-driven and informed delivery of primary care services. The UTSCAP Network is in an early stage of development and growth and is actively recruiting community-based primary care physicians and their practices to join UT Southwestern faculty physicians. In DY3, we will report on the number of Network physicians that will be the basis for measuring improvement through this project. As of December 1, 2011, UT Southwestern and its Network has not established a menu of nationally recognized, quality improvement measures, nor has it created a quarterly reporting mechanism to inform physicians of their status in delivering quality, primary care services. In addition, the Network does not have a quality incentive program for Network physicians. Thus, the starting point for this project is zero (0).

Rationale

UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, 24% of UTSW patient charges were attributed to Medicaid patients across Parkland, Children's and UT Southwestern. Thus, UT Southwestern physician services are directly impacted by the negative outcomes created by inefficient, ineffective care delivery.

UT Southwestern is uniquely positioned to influence a practice's decision to participate in quality assurance programs to benefit all RHP 9 patient populations by virtue of our extensive and combined experience in teaching, research, and clinical performance. There are a number of other very tangible benefits associated with participating in UT Southwestern's clinically integrated network (the UTSCAP Network), and we believe community physicians will embrace

the opportunity to partner around this quality initiative. However, this influence alone will not be sufficient to have the impact necessary to meaningfully increase primary care capacity for this patient population. Making it economically feasible for practices to provide care in the right setting, at the right time, and by the right provider will hasten the transition towards the delivery of quality primary care in RHP 9. This program will better align provider incentives, with the quality care model they desire to provide, and provide high quality, cost effective primary care access to RHP 9 patient populations.

Finally, current reimbursement models represent a substantial obstacle for physician practices implementing evidence-based initiatives. Today's system can perversely encourage physicians to minimize access for certain patients and attempt to see extensive number of other patients each day in order to make ends meet. Under this scenario, physicians can't spend the amount of time necessary to deal with health issues they might otherwise be able to address in the primary care office. As a result, patients are often referred into specialists for care that could otherwise be provided in a primary care office. This leads to long waits in specialty clinics and a system cost that is higher than it needs to be. Even worse, long delays for specialty care often lead patients to seek care in hospital emergency departments, which further financially burdens the system. UT Southwestern anticipates that by providing this quality incentive program, all RHP 9 patients, including those not currently experiencing a fully integrated and incentive aligned model, will enjoy higher quality care and an enhanced patient care experience.

Project Component:

To accomplish UTSW's ultimate goal to expand primary care capacity to accommodate RHP 9 patients receiving the right care, at the right time, in the right setting, and by the right provider, we must focus on multiple key areas. The core element necessary for success is to implement an evidence-based quality assurance program that will incent primary care providers in RHP 9 to innovate on quality assurance for all patient populations. To progress towards this objective, UTSW has selected a number of milestones and metrics that are relevant to the community needs and priorities of RHP 9

Community Needs Addressed

The specific and unique community need identification numbers that this project addresses include the following:

- CN.9-Chronic Disease
- CN.11-Patient Safety and Quality
- CN.12-Emergency Department Usage and Readmissions

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

Most experts agree that addressing reimbursement incentives is a key component significantly enhancing the existing delivery system. Said differently, we have to pay for what we want from

healthcare providers. Therefore, we believe an important part of the solution to expanding primary care access will be to financially enable finite primary care resources to make the investments necessary to provide evidence-based quality care to all patient populations. However, adding money to the system alone will not adequately resolve the issue. For this reason our proposed solution requires physicians to first open up their practice to patients, meet quality requirements, which will then result in the distribution of quality incentive payments. As described earlier, this is similar to other reform initiatives where physicians have to meet various objective quality standards before participating in financial incentives. The enhancement derived from this program is that it provides this incentive to provide quality care to the broader RHP9 patient population.

Related Category 3 Outcome Measure(s):

OD-12 Primary Care and Primary Prevention Outcomes:

- IT-12.1 Breast Cancer Screening (HEDIS 2012)
- IT-12.3 Colorectal Cancer Screening (HEDIS 2012)
- IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012)

Reasons/rationale for selecting the outcome measures

Our development and implementation of a quality incentive program available to UTSCAP Network physicians is aimed at increasing the likelihood of desired health outcomes. We selected the above outcomes because measuring, reporting and acting upon quality improvement measures for primary care should result in the increased incidence of preventative services actually delivered to patients. We subscribe to the theory that screening programs should lead to a cost-effective reduction in disease burden. UT Southwestern will focus on these outcomes for all our attributed patients, irrespective of their socioeconomic status. As a result, we believe focusing on these outcomes will make a measurable difference for individuals in RHP 9 at all income levels.

Relationship to other Projects

The success of this initiative is highly dependent on the implementation of the following other projects proposed by UT Southwestern: This project is tightly linked to the following RHP projects:

- ***126686802.2.2.2—Applying process improvement methodology to improve quality and efficiency by training in the methodology of quality improvement.***
- ***126686802.1.1.2—Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics.***
- ***126686802.2.1.1—Expanding the Medical Home Model in the UTSCAP Primary Care Network.***

- ***126686802.1.10.2—Implement UT Southwestern Population Management Infrastructure Development:*** UTSCAP Primary Care Network clinics will provide services to Network patients via a Network-wide population management infrastructure.

- ***126686802.2.9.1—Implement/Expand Care Coordination Programs:*** UTSCAP Primary Care Network clinics will provide services to Network patients via access to the Network's care coordinators, ensuring that all Network patients receive coordinated, timely, and site-appropriate health care services.

- ***126686802.2.12.1—Expanding Care Transition Programs:*** The development, implementation and evaluation under standardized protocols and evidence-based care delivery model through a network of post-acute care providers to improve the care delivered to people during transitions of care will rely heavily on robust population management infrastructure.

Plan for Learning Collaborative

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criterion:

1. Transformational Impact (Weight=20%): Points were awarded for projects that meet the community benefit criteria. Score– 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). **This project's score for this criterion: 5 X 2 = 10**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population. **This project's score for this criterion: 4.5 X 2 = 9**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues. **This project's score for this criterion: 4.5 X 2 = 9**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person. **This project's score for this criterion: 4.7 X 2 = 9.4**

6. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability. **This project's score for this criterion: 5 X 2 = 10**

Total Valuation Score for this project: **9.4**
These values are provided for in the table below and are allocated equally amongst the milestones.

126686802.1.3	***PROJECT OPTION*** **1.1.4**	***PROJECT COMPONENT(S)*** ***NON REQUIRED***	***Implement a quality incentive program for primary care providers***	
UT Southwestern Medical Center Faculty Practice Plan				*126686802*
Related Category 3 Outcome Measure(s):	126686802.3.7 126686802.3.8 126686802.3.9	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening 3. Pneumonia Vaccination Status of 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-X]: Constitute Utilization and Quality Improvement Committees. Metric 1.1 [P-X.1]: Documentation of Committee Charters and minutes. Baseline: No UM/QI Committees/Charters Goal: Develop charters Data Source: Committee charter documents. **Milestone 1 Estimated Incentive Payment: $975,625** **Milestone 2** [P-X]: Constitute Utilization and Quality Improvement Committees. Metric 2.1 [P-X.1]: Establish the membership roster for the Utilization and Quality Improvement Committees that includes representation of UTSCAP Network physicians—both UTSW faculty primary care physicians and affiliated community-based primary care physicians. Baseline: No UM/QI Committees members Goal: Appoint 5 plus committee members to each committee and hold 1 or more meetings. Data Source: Committee Roster, appointments, and/or minutes.	**Milestone 5** [P-X]: Establish baseline measures for the menu of quality measures. Metric 5.1 [P-X.1]: Establish the quality baseline performance of UTSCAP Network. Baseline: No established baseline Goal: Quantitative baseline by quality measure. Data Source: Registry, CDR, and/or reporting systems. **Milestone 5 Estimated Incentive Payment: $857,086** **Milestone 6** [P-X]: Establish quality measure baselines for each participating physician. Metric 6.1 [P-X.1]: Documentation of the baseline for each quality measure from the menu per Network physician . Baseline: No established baseline. Goal: 75% of qualifying Network physicians have a documented baseline for each quality measure listed in the menu. Data Source: Registry, CDR, reporting systems, practice EMR,	**Milestone 10** [I-X]: Quarterly measure and report performance regarding the menu of quality measures to the Network primary care physicians Metric 10.1 [I-X.1]: Increase the number Network primary care physicians being measured and reported against established Network quality measures. Baseline: Zero (0) Goal: 75% of qualified Network physicians are measured and receive a quarterly report of their performance. Data Source: Registry, CDR, reporting systems, practice EMR, and/or claims data. **Milestone 10 Estimated Incentive Payment: $916,882** **Milestone 11** [I-X]: Improve quality within the Network. Metric 11.1 [I-X.1]: Increase the number of qualified Network primary care physicians meeting an established quality improvement goal/ target. Baseline: Established in	**Milestone 15** [I-X]: Quarterly measure and report performance regarding the menu of quality measures to the Network primary care physicians Metric 15.1 [I-X.1]: Increase the number Network primary care physicians being measured and reported against established Network quality measures. Baseline: 75 % of qualified Network physicians Goal: 85% of qualified Network physicians are measured and receive a quarterly report of their performance. Data Source: Registry, CDR, reporting systems, practice EMR, and/or claims data. **Milestone 15 Estimated Incentive Payment: $885,877** **Milestone 16** I-X]: Improve quality within the Network.

126686802.1.3	***PROJECT OPTION*** **1.1.4**	***PROJECT COMPONENT(S)*** ***NON REQUIRED***	***Implement a quality incentive program for primary care providers***	
UT Southwestern Medical Center Faculty Practice Plan				*126686802*
Related Category 3 Outcome Measure(s):	126686802.3.7 126686802.3.8 126686802.3.9	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening 3. Pneumonia Vaccination Status of 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 2 Estimated Incentive Payment: $975,625 **Milestone 3** [P-X]: Review and establish a menu of quality measures for the Incentive Program based on nationally recognized measures. Metric3.1: Establish menu of evidence based quality measures to monitor Baseline: No menu of measures Goal: Adopted set of measures Data Source: Documented set of QI committee approved measures. **Milestone 3 Estimated Incentive Payment: $975,625** **Milestone 4** [P-X]: Ensure necessary information resources are in place to enable standardized reporting across Network participants. Metric 4.1: Acquire/implement necessary information systems to facilitate Network monitoring /reporting. Baseline: No system(s) in place Goal: Implemented reporting system. Data Source: Documented of registry, CDR, and/or reporting systems.	and/or claims data. **Milestone 6 Estimated Incentive Payment: $857,086** **Milestone 7** [P-X]: Establish the Network's quality improvement targets (improvement milestones progressing towards the Network's long-term goal) to serve as the basis for incentive payments to Network physicians. Metric 7.1 [P-X]: Document the establishment of these targets for each quality measure on the Incentive Program Quality Menu. Baseline: No established targets. Goal: 75% of all quality measures listed in the menu have a documented target for improvement that include milestones progressing towards the Network's long-term goal/ target. Data Source: Registry, CDR, reporting systems, practice EMR, and/or claims data. **Milestone 7 Estimated Incentive Payment: $857,086**	Milestone 7 and reported in DY3. Goal: 50% of qualified Network physicians attained an established quality improvement milestone. Data Source: Registry, CDR, reporting systems, practice EMR, and/or claims data. **Milestone 11 Estimated Incentive Payment: $916,882** **Milestone 12** [I-X]: Improvements in access to primary care for patients through using innovative quality incentive program. Metric 12.1 [I-X.1]: Documentation of increased number of unique patients served by innovative program Baseline: Established and reported in Milestone 9 of DY3. Goal: 3% increase over baseline. Data Source: Registry, CDR, reporting systems, practice EMR, and/or claims data. **Milestone 12 Estimated Incentive Payment: $916,882** **Milestone 13** [I-X]: Improvements in	Metric 16.1 [I-X.1]: Increase the number of qualified Network primary care physicians meeting an established quality improvement goal/target. Baseline: 50% of qualified Network physicians meeting a quality target. Goal: 75% of qualified Network physicians meeting a quality target. Data Source: Resigstry, CDR, reporting systems, practice EMR, and/or claims data. **Milestone 16 Estimated Incentive Payment: $885,877** **Milestone 17** [I-X]: Improvements in access to primary care for patients through using innovative quality incentive program. Metric 17.1 [I-X.1]: Documentation of increased number of unique patients served by innovative program Baseline: Number of unique patients served at the end of

126686802.1.3	***PROJECT OPTION*** **1.1.4**	***PROJECT COMPONENT(S)*** ***NON REQUIRED***	***Implement a quality incentive program for primary care providers***	
UT Southwestern Medical Center Faculty Practice Plan				*126686802*
Related Category 3 Outcome Measure(s):	126686802.3.7 126686802.3.8 126686802.3.9	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening 3. Pneumonia Vaccination Status of 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 4 Estimated Incentive Payment: $975,625		**Milestone 8** [P-X]: Develop Clinical Protocols aimed at improving selected quality measures for the Incentive Program. Metric 8.1 [P-X.1]: Documentation of Clinical Protocols that are readily available to Network physicians via an electronic "Network Clinical Protocol Library". Baseline: No established protocol library. Goal: Develop protocols for top 5 quality measures listed in the menu aimed at assisting the Network physician's in reaching the quality measure's goal/ target. Data Source: Registry, CDR, reporting systems, practice EMR, and/or claims data. **Milestone 8 Estimated Incentive Payment: $857,085** **Milestone 9** [P-X]: Documentation of patients served in the innovative quality incentive program. Metric 9.1 [P-X.1]: Document the number of unique patients served by innovative quality incentive	access to primary care for patients through using innovative quality incentive program. Metric 13.1 [I-X.1]: Improved clinical outcomes of target population. The clinical outcomes can be either intermediate or end result. Baseline: Established in Milestone 7 of DY3. Goal: 5% improvement in 3 or more measures. Data Source: Registry, EHR, claims or other Performing Provider source **Milestone 13 Estimated Incentive Payment: $916,882** **Milestone 14** [I-X]: Improvements in access to primary care for patients through using innovative quality incentive program. Metric 14.1 [I-X.1]: Improved compliance with recommended care regimens. Baseline: Established in Milestone 8 of DY 3. Goal: Document 75% of qualifying Network physicians are following an established Network protocol. Data Source: Registry, EHR, claims or	DY4 Goal: 2% increase over baseline. Data Source: Registry, CDR, reporting systems, practice EMR, and/or claims data. **Milestone 17 Estimated Incentive Payment: $885,877** **Milestone 18** [I-X]: Improvements in access to primary care for patients through using innovative quality incentive program. Metric 18.1 [I-X.1]: Improved clinical outcomes of target population. The clinical outcomes can be either intermediate or end result. Baseline: Results at the end of DY4 Goal: 5% improvement over baseline in 3 or more measures. Data Source: Registry, EHR, claims or other Performing Provider source **Milestone 18 Estimated**

126686802.1.3	*PROJECT OPTION* **1.1.4**	*PROJECT COMPONENT(S)* *NON REQUIRED*	*Implement a quality incentive program for primary care providers*	
UT Southwestern Medical Center Faculty Practice Plan				*126686802*
Related Category 3 Outcome Measure(s):	126686802.3.7 126686802.3.8 126686802.3.9	IT-12.1 IT-12.3 IT-12.4	1. Breast Cancer Screening 2. Colorectal Cancer Screening 3. Pneumonia Vaccination Status of 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)**
		program. Baseline: Zero (0) patients served. Goal: Establishment of the number of unique patients being served. Data Source: Registry, EHR, claims or other Performing Provider source **Milestone 9 Estimated Incentive Payment: $857,085**	other Performing Provider source **Milestone 14 Estimated Incentive Payment: $916,883**	**Incentive Payment: $885,876** **Milestone 19** [I-X]: Improvements in access to primary care for patients through using innovative quality incentive program. Metric 19.1 [I-X.1]: Improved compliance with recommended care regimens. Baseline: 75% of qualifying Network physicians. Goal: Document 85% of qualifying Network physicians are following an established Network protocol. Data Source: Registry, EHR, claims or other Performing Provider source **Milestone 19 Estimated Incentive Payment: $885,876**
Year 2 Estimated Milestone Bundle Amount: **$3,902,500**		Year 3 Estimated Milestone Bundle Amount: **$4,285,428**	Year 4 Estimated Milestone Bundle Amount: **$4,584,411**	Year 5 Estimated Milestone Bundle Amount: **$4,429,383**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***: $17,201,722**				

Appendix A

1.0 COMPREHENSIVE PRIMARY CARE INITIATIVE PHYSICIAN GATEWAY REQUIREMENTS (Prospective Incentive)

A practice must be a primary care practice and as such:

- Provide the first point of contact for patients and ongoing care;
- Led by a board-eligible PCP, geriatrician or advanced practice nurse (as allowed by state law);
- Composed of predominantly, but not necessarily exclusively, primary care providers;
- Provide predominantly, but not necessarily exclusively, primary care services;
- Have National Provider Identifiers (NPIs) and Tax Identification Numbers (TINs);
- Be geographically located in a selected market;
- Open to Medicaid beneficiaries;
- Building toward a critical mass of beneficiaries supportive of population management principles;
- Use an electronic health record (EHR) system and qualify for meaningful use incentives or successor programs;
- Implementation of applicable patient registry and/or point of care tools required to satisfy applicable reporting;
- Use of electronic system to write prescriptions;
- Meeting participation (regional meetings, governance, etc.);
- Cooperation with Care Coordination Program and Staff; and
- Endorse and integrate PCMH principles leading to future NCQA PCMH Recognition.

Appendix B

2.00	COMPREHENSIVE PRIMARY CARE INITIATIVE GATEWAY METRICS (Retrospective Incentive)		
2.01	Health Risk Assessment Completion / Submission	As Indicated - All Applicable Patients	Complete and submit specific risk assessment from with appropriate diagnoses and reimbursement codes
2.02	Percentage extended exam within past 12 months	As Indicated - All Applicable Patients	As recorded in applicable EMR field
2.03	Childhood Immunization	As Indicated - All Applicable Patients	As recorded in applicable EMR field
2.04	Adult influenza immunization	As Indicated - All Applicable Patients	As recorded in applicable EMR field
2.05	Patient education provided for obesity	As Indicated - All Applicable Patients	As recorded in applicable EMR field
2.06	Well-baby patients utilizing benefits	As Indicated - All Applicable Patients	As recorded in applicable EMR field
2.07	Medical assistance with smoking cessation	As Indicated - All Applicable Patients	As recorded in applicable EMR field
2.08	BMI assessed and documented	As Indicated - All Applicable Patients	As recorded in applicable EMR field
2.09	Medication monitoring (appropriate lab annually)	Patients on ACE/ARB, Digoxin, Diuretic, or Anti-convulsants	ACE/ARB, Digoxin, or Diuretic – Serum K+ yearly with either Cr or BUN Anti-convulsant – Drug level yearly
2.10	Generic medication utilization	Generic Rate % on All Prescriptions	Generic drug days as percentage of all drug days filled based on prescription data
2.11	Inpatient follow-up	All patients discharged from hospital	Office appointment or consult billed within 7 days of hospital d/c

Appendix C

4.00	**INCENTIVE AMOUNTS**	**Gateway Requirements**	**Gateway Metrics**
4.01	DY 2	Finalize Program	Finalize Program
4.02	DY3	Prospective PMPM Amount - as determined Annually	Retrospective PMPM Amount - as determined annually
4.03	DY4	Prospective PMPM Amount - as determined Annually	Retrospective PMPM Amount - as determined annually
4.04	DY5	Prospective PMPM Amount - as determined Annually	Retrospective PMPM Amount - as determined annually

Appendix D

Find supporting documentation in attached .pdf files.

Project Option 1.7.1 - Introduce, Expand, or Enhance Telemedicine/Telehealth

***Unique Project ID*:** 126686802.1.4
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW") Faculty Practice Plan/126686802

Summary Information
Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds 452-beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, UTSW physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices.

Intervention(s): This project will implement telemedicine to provide specialty care support and consultation throughout the UTSCAP Primary Care Network to better accommodate the needs of RHP 9 patients and the community.

Need for the Project: As we build the UTSCAP Network and actively recruit community-based primary care physicians and their practices into the Network, we must be able to provide the patients of these clinics with cost-effective specialty care access and services.

Target Population: The target population is our UTSCAP Network patients receiving primary care and potentially needing access to specialty care. Approximately 3% of our patients are either Medicaid eligible or indigent, so we expect they will benefit from 3% of the telemedicine consults.

Category 1 or 2 Expected Patient Benefits: UTSW will substantially add to the number of patients in RHP 9 that will have access to telemedicine services. We anticipate adding 126 primary care physicians to the Network and promoting telemedicine opportunities to these physicians and their patients. UTSW expects this will mean by DY5 approximately 277,000 patients, including 44,000 Medicaid/low income patients, could avail themselves of some type of telemedicine services.

The project seeks to determine needs by specialty to increase access to primary care and referrals. This will include education of the providers and patient population as well as establish 2 or more UTSCAP Network telemedicine-enhanced clinics that include services such as evaluation, diagnosis, treatment and education by specialty physicians. We expect to provide 100 telemedicine visits and 10 or more visits per month in 2 or more clinics identified as 'high need' by DY 5. In addition, further extending the reach of the program will be

application of telehealth/telemonitoring activities for the more acute or complex patients that will keep their health monitored more closely and reduce or avoid acute and ER risk.

Category 3 Outcome Measures:

- IT-1.6 Cholesterol Management
- IT-1.7 Controlling high blood pressure
- IT-1.10 Diabetes Care: HgbA1C

Project Description

UT Southwestern proposes to introduce access to specialty care support and consultation via telemedicine to the UTSCAP Primary Care Network to better accommodate the needs of RHP 9 patients and the community.

The UTSCAP Primary Care Network (the "Network") is designed to integrate community-based primary care physicians and the faculty physicians of UT Southwestern Medical Center ("UT Southwestern"). The Network is in an early stage of development and growth and is actively recruiting community-based primary care physicians and their practices to join UT Southwestern faculty physicians. The ultimate goal of the Network is delivering patient care at the highest level of quality by the most cost-effective means, achieved through the clinical integration of Network physicians. Such outcomes are good for patients, payors, physicians and the community. The specific short and long-term objectives for the Network include:

- Expanding, strengthening and implementing a clinically integrated network;
- Developing an infrastructure for effective care coordination of Network patients;
- Enhancing and continually developing a clinically integrated organizational structure in preparation of health care reform and value-based reimbursement; and
- Advancing the use of technology to improve health care, extend access, and reduce medical errors.

This project will improve access to specialty care services by defining and creating a robust telemedicine system connecting Network primary care physicians and their patients with Network specialists. As community-based primary care physicians join the Network, they will no longer be practicing in "isolation" and be given direct and consistent access to specialists for Telehealth evaluation and referral activities. Through clinical integration with UT Southwestern faculty physicians and access to the Network's telemedicine system, these community-based primary care physicians will engage in the continual development and implementation of clinical "best practices" with the Telemedicine enhancements for District patients. Overall, the telemedicine program is aimed at telemedicine encounters becoming an important part of introducing patients early into needed specialty care or, just as important, determining that specialty care is not needed at that time. Additionally, ongoing connectivity to specialty care

will improve outcomes by reducing the incidence of complications through early assessment, detection, and chronic-case monitoring.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relations to Regional Goals:

The goals of this project are as follows:

- Identify needed specialty services that can be delivered via telemedicine through the completion of a comprehensive needs assessment.
- Implement a telemedicine program for selected medical specialties, based upon regional and community need.
- Provide Network patients in need of selected medical specialty services access to these services via a specific telemedicine delivered service.
- Provide UTSCAP Primary Care clinics access to the telemedicine specialty services for specialty telemedicine visits.
- Partner with our community-based physicians to improve chronic disease management and reduce potentially preventable readmissions.
- Implement tele-monitoring of indicated patients to maximize avoidable deterioration of conditions and improve quality of life while reducing unnecessary acute / ER care.

This project also meets the following regional goals:

A goal of the region is to provide improved access to specialty care at the right time to meet the needs of our patients, to improve the health of our patients, and to create a "real system" of care delivery. This project would contribute to achieving that goal by expanding access to specialty care services via telemedicine. In addition, emergency department utilization is high in RHP 9 and by providing more patients with timely access to specialty care, this project helps achieve the a regional goal to keep patients from unnecessarily using the emergency departments and urgent care centers as a means to receive basic care.

Challenges:

Today, telemedicine services remain largely un-reimbursable and rules to change historical patterns or care are not fully finalized. Current solutions for cross-consultation are primarily informal peer-to-peer relationships established over time with appointment referrals directed for an office visit. The UTSCAP Network physicians (both UT Southwestern faculty physicians and the affiliated community-based primary care physicians) will require evaluation,

infrastructure, training and socialization into the improved access afforded through the proposed telemedicine program project.

Within the Network, telemedicine development would be introduced in phases as regional relationships are established and medical homes are expanded. A key challenge is the geography and large number of providers and health systems where patients may present themselves. Another challenge is the deployment of the technology necessary to support the geography and build a model responsive to the needs of patients and their physicians. Patients would have to be identified as candidates based on condition in advance or early within a visit to bring together the timing of a telemedicine events. UT Southwestern would overcome these challenges by carefully evaluating the necessary deployment of the technology, sharing information in a secured way, introducing Network physicians into the telemedicine environment and developed protocols specific to the use of telemedicine in the delivery of care, and educating patients to the benefits of access to specialty services via telemedicine. As there is more to the project than creating the technology, the investment in technology, integration, education, and cooperation of the providers will be a challenging task that has a high reward for the investment in building another entire channel to care that will not impede schedules or traditional visits for those confirmed to need a direct consultation or referral.

5-Year expected outcomes for providers and patients:

Between December 2010 and November 2011, UTSW physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices. UTSW will substantially add to the number of patients in RHP 9 that will have access to telemedicine services. We anticipate adding 126 primary care physicians to the Network and promoting telemedicine opportunities to these physicians and their patients. UTSW expects this will mean by DY5 approximately 277,000 patient, including 44,000 Medicaid/low income patients, could avail themselves of some type of telemedicine services. While not all patients will utilize telemedicine services, there will be available access. We anticipate 1,100,000 overall and 177,000 Medicaid/low income primary care patient contacts per year in DY5. Over the course of this project we expect this enhanced care access will reduce unnecessary utilization and provide care that would otherwise be provided in higher cost settings.

The implementation of a telemedicine program will expand access to specialty care within our region. As we identify the specialty services in the greatest demand within our region and address this need through the telemedicine program, the 5-year expected outcome will be the establishment of UTSCAP Network telemedicine-enhanced clinics that provide at least ten telemedicine visits per month. Patients will have received access to Specialists within a Primary Care visit to diagnostic and treatment consultative services via a specific telemedicine delivered service. Direct Telemedicine visits for specialty services/evaluations will also be conducted at a decreased resource / time level relative to traditional visits. Finally, physicians will be educated and inclined to utilize an integrated Telemedicine approach into their practice patterns to improve efficiency while extending their reach for the community.

Patient outcomes will be improved by the resulting increase in access points to specialty services. We anticipate that patients will be engaged earlier and connected more frequently in a way that supports earlier specialist consultation and clinical evaluation, diagnosis and treatment, monitoring, and education on improving health.

Starting Point/Baseline

UT Southwestern has some experience with delivering telemedicine services. For example, UT Southwestern has provided teleradiology services and wound-care telemedicine services for residents of the Denton State Supported Living Center (DSSLC). DSSLC is the largest of 12 State Living Centers in Texas and home to over 525 intellectually and physically disabled individuals. DSSLC is located on 200 wooded acres in Denton County. However, the starting point for this initiative is zero (0) since this telemedicine program is designed to extend specialty services to primary care physicians and their patients within RHP 9.

Rationale

As an academic medical center, UT Southwestern physicians provide innovative, patient-oriented medical services ranging from preventive care to world-class treatment in a wide variety of specialties, including cardiology, cardiothoracic surgery, cancer, heart and lung transplantation, neurosurgery, orthopaedic surgery, otolaryngology, obstetrics and gynecology, urology, breast surgery, vascular surgery, pediatrics, infectious disease, and much more. Moreover, UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. UT Southwestern's faculty physician practice is one of the largest providers of physician services to the Medicaid program in Texas. For example, between December 2010 and November 2011, UT Southwestern physicians provided outpatient services to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices. Thus, UT Southwestern physician services are directly impacted by the negative outcomes created by inadequate access to efficient, quality specialty care services.

With the region standing at the forefront of Healthcare Reform, coupled with the downward pressure on service utilization, cost, and reimbursement – UT Southwestern sees the need to make investments in technology that supports expanded access to specialty services. As we build the UTSCAP Network and actively recruit community-based primary care physicians and their practices to join UT Southwestern faculty physicians, we must be prepared to provide these Network physicians and their patients efficient, cost-effective specialty care access and services. Being centrally located and faced with a population that has geographical, monetary, and other restrictions in accessing healthcare, UT Southwestern needs to develop outreach programs that share ownership of the results and bridge areas where patients may not engage on their own. Our Network community-based primary care physicians need to focus on primary care issues, with strong specialty support provided by Network specialists (UT Southwestern faculty physicians) via telemedicine services that create an environment of knowledge sharing.

This environment is necessary to evaluate patients efficiently, make only targeted referrals to specialists, and then appropriately transition these patients back to their primary care physician as soon as medically appropriate.

Delayed referral to and assessment by specialists creates a patient population with greater levels of healthcare status acuity and invites complications from co-morbidities. Improved and timely access to specialists will engage more physicians quicker while limiting face-to-face specialty visits except for those cases deemed necessary through the telemedicine consultation. Telemedicine services will also avoid the duplication of diagnostic efforts and decrease unnecessary hospital readmissions, as well as engaging patients in referrals, evaluation, treatment, and monitoring activities to keep health, condition stability, and outcomes optimal.

Project Components

To accomplish UTSW's ultimate goal of implementing a telemedicine program, UTSW's project includes the following core elements:

1) Complete a comprehensive evaluation of Telemedicine and Telehealth needs for the population, considering the technical, professional, education, and patient needs to reach project goals.

2) Develop the necessary Telemedicine infrastructure, training, education, and professional support needed to extend meaningful access and results.

3) Provide patient consultations by medical and surgical specialists as well as other types of health professionals using telecommunications. Determine candidates and deploy Telehealth technology to engage patients, promote Telemonitoring specific conditions, and

4) 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.

Community Needs Addressed:

The specific and unique community need identification numbers that this project addresses include the following:

- CN.2-Regional Healthcare Infrastructure and Patient Migration Patterns

- CN.3-Healthcare Capacity
- CN.8-Specialty Care
- CN.12-Emergency Department Usage and Readmissions

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

Given the challenges noted above, telemedicine has not been effectively deployed or available to the majority of the patient population in RHP9. UT Southwestern feels that by committing the resources contemplated in this project and deploying them into the community as described herein, the RHP9 delivery system will be enhanced. With the potential to reduce ER visits, urgent care visits, specialty visits, and facilitating early intervention, a properly implemented telemedicine program could be very impactful to RHP 9.

Related Category 3 Outcome Measure(s)

OD-1 Primary Care and Chronic Disease Management:

- IT-1.6 Cholesterol management for patients with cardiovascular conditions
- IT-1.7 Controlling high blood pressure
- IT-1.10 Diabetes care: HgbA1c poor control (>9.0%)

Reasons/rationale for selecting the outcome measures

The primary goal of this project is to transform the delivery of specialty care, which should result in better access and clinical outcomes for our patients. Of great concern in our region and nationally, is the prevalence of diabetes and heart disease. Thus, we chose IT-1.6, IT-1.7, and IT-1.10 for the outcome measures associated with this project. Improving access and ability to "reach out" to patients is a key ingredient to effecting the outcomes expected.

UTSW will be focusing on this outcome for all our attributed patients, irrespective of their socioeconomic status. As a result, we believe focusing on these outcomes will make a measurable difference for individuals in RHP 9 at all income levels.

Relationship to other Projects

The success of this initiative is highly dependent on the implementation of the following other projects proposed by UT Southwestern: This project is tightly linked to the following RHP projects:

- ***126686802.2.2.2—Applying process improvement methodology to improve quality and efficiency by training in the methodology of quality improvement:***

- ***126686802.1.1.2—Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics:***

- ***126686802.2.1.1—Expanding Medical Home Model in the UTSCAP Primary Care Network:***

- ***126686802.1.10.2—Implement UT Southwestern Population Management Infrastructure Development:*** UTSCAP Primary Care Network clinics will provide services to Network patients via a Network-wide population management infrastructure to improve quality and efficiency in the care they deliver.

- ***126686802.2.9.1—Implement/Expand Care Coordination Programs:*** UTSCAP Primary Care Network clinics will provide services to Network patients via access to the Network's care coordinators, ensuring that all Network patients receive coordinated, timely, and site-appropriate health care services.

- ***126686802.2.12.1—Expanding Care Transition Programs:*** The development, implementation and evaluation under standardized protocols and evidence-based care delivery model through a network of post-acute care providers to improve the care delivered to people during transitions of care will rely heavily on robust population management infrastructure.

Relationship to Other Performing Providers' Projects in the RHP

Other projects in RHP 9 related to telemedicine/Telehealth include the following:

121988304.1.2	Lakes Regional MHMR (Behavioral Health)
020943901.1.1	Medical City Dallas Hospital – Stroke
020943901.1.2	Medical City Dallas Hospital – Behavioral Health

Plan for Learning Collaborative

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). **This project's score for this criteria: 4.5 X 2 = 9**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population. **This project's score for this criteria: 4.5 X 2 = 9**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues. **This project's score for this criteria: 4.5 X 2 = 9**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person. **This project's score for this criteria: 3.9 X 2 = 7.8**

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 3.5 X 2 = 9

Total Valuation Score for this project: **8.7**

These values are provided for in the table below and are allocated equally amongst the milestones.

126686802.1.4	***PROJECT OPTION 1.7.1***	***PROJECT COMPONENT(S) 1.7.1 (A-B)***	***INTRODUCE, EXPAND, OR ENHANCE TELEMEDICINE/TELEHEALTH***	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measure(s):	*12686802.3.10* *12686802.3.11* *12686802.3.12*	*IT-1.6* *IT-1.7* *IT-1.10*	*Cholesterol management* *Controlling high blood pressure* *Diabetes care: HbA1c poor control (>9.0%)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: [P-1] Conduct needs assessment to identify needed specialties that can be provided via telemedicine Metric 1.1: P-1.1. Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel. Baseline: No needs assessment Goal: Submission of completed needs assessment Data Source: Needs assessment **Milestone 1 Estimated Incentive Payment: $1,801,154** **Milestone 2** [P-2] Conduct needs assessment to identify needed services that could be delivered via telehealth Metric 2.1 [P-2.1]: Needs assessment Baseline: No needs assessment Goal: Submission of completed needs assessment. Data Source: Needs assessment **Milestone 2 Estimated Incentive**	**Milestone 3** [P-3]: Implement or expand telemedicine program for selected medical specialties, based upon regional and community need. Metric 3.1 [P-3.1]: Documentation of program materials including implementation plan, vendor agreements/contracts. Staff training and HR documents. Baseline: No implementation plans/materials Goal: Submission of implementation documentation. Data Source: Implementation plan/program materials **Milestone 3 Estimated Incentive Payment: $988,945** **Milestone 4 [P-4]** Implement or expand Telehealth program for targeted health services, based upon regional and local community need. Metric 4.1: Documentation of program materials including implementation plan, vendor agreements/ contracts, staff training and HR documents. Baseline: No implementation plans or	**Milestone 7** [P-3] Implement or expand telemedicine program for targeted health services, based upon regional and community need. Metric 7.1 [P-3.2] Documentation of number of consults delivered by each specialty Baseline: Establish Baseline for The number of patients who received diagnostic and treatment services via a specific telemedicine delivered service; Goal: 100 telemedicine visits. Data Source: clinic Log of tele-services by telemedicine service, EMR, and/or other reporting tool. **Milestone 7 Estimated Incentive Payment: $846,353** **Milestone 8** [I-12]: Increase number of telemedicine visits for each specialty identified as high need. Metric 8.1 [I-12.1]: Number of telemedicine visits Baseline: Number of patients referred to medical specialties Goal: 100 or more visits in 2 or more specialties. Data Source: EHR or electronic referral	**Milestone 12** [I-16]: Expand telemedicine-enhanced clinics Metric 12.1[I-16.1]: New telemedicine-enhanced clinics Baseline: Number of UTSW enhanced clinics available during DY 4. Goal: Add 5 Network telemedicine-enhanced clinics over baseline. Data Source: Appointment scheduling software records **Milestone 12 Estimated Incentive Payment: $817,732** **Milestone 13 [P-3]** Implement or expand telemedicine program for selected medical specialties, based upon regional and community need. Metric 13.1: P-3.2 Documentation of the number of consults delivered by each specialty Baseline: DY 4 telemedicine visits. Goal: 5% increase over baseline. Data Source: clinic log of health services by telemedicine service; **Milestone 13 Estimated Incentive Payment: $817,732**

126686802.1.4	***PROJECT OPTION 1.7.1***	***PROJECT COMPONENT(S) 1.7.1 (A-B)***	***INTRODUCE, EXPAND, OR ENHANCE TELEMEDICINE/TELEHEALTH***	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measure(s):	*12686802.3.10* *12686802.3.11* *12686802.3.12*	*IT-1.6* *IT-1.7* *IT-1.10*	*Cholesterol management* *Controlling high blood pressure* *Diabetes care: HbA1c poor control (>9.0%)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Payment: $1,801,154	program materials Goal: Submission of implementation documentation Data Source: Implementation plans/program materials. **Milestone 4 Estimated Incentive Payment: $988,945** **Milestone 5 [P-5]** Implement remote patient monitoring program based on evidence based models and adapted to fit the needs of the population and local context. Metric 5.1: [P-5.1] Documentation of program materials including implementation plan, vendor agreements/ contracts, staff training and HR documents. Baseline: No remote monitoring program. Goal: Submission of implementation plan and program documentation. Data Source: Implementation plan/program materials. **Milestone 5 Estimated Incentive Payment: $988,945** **Milestone 6 [I-17]** Improved access to	processing system; encounter records from telemedicine program **Milestone 8 Estimated Incentive Payment: $846,353** **Milestone 9 [I-18]** Implement interventions to achieve improvements in access to care of patients receiving telemedicine/Telehealth services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to achieve improvements in access to care of patients receiving telemedicine /Telehealth services but are not required. Metric 9.1: [I-18.2] Number of telemedicine/Telehealth visits Baseline: Number of telemedicine visits provided in DY3. Goal: 250 Telemedicine / Telehealth visits (direct consult, store & forward, etc.) for peer-to-peer consultation, patient evaluation, and specialist referrals above baseline Data Source: Registry, EHR, claims or other Performing Provider source **Milestone 9 Estimated Incentive Payment: $846,353**	**Milestone 14 [I-12]** Increase number of telemedicine visits for each specialty identified as high need Metric 14.1: [I-12.1] Number of telemedicine visits Baseline: Number of patients referred to medical specialties in DY4. Goal: 5% increase over baseline. Data Source: EHR or electronic referral processing system; encounter records from telemedicine program **Milestone 14 Estimated Incentive Payment: $817,732** **Milestone 15 [I-18]** Implement interventions to achieve improvements in access to care of patients receiving telemedicine/Telehealth services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to achieve improvements in access to care of patients receiving telemedicine/Telehealth services but are not required.

126686802.1.4	***PROJECT OPTION 1.7.1***	***PROJECT COMPONENT(S) 1.7.1 (A-B)***	***INTRODUCE, EXPAND, OR ENHANCE TELEMEDICINE/TELEHEALTH***	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measure(s):	*12686802.3.10* *12686802.3.11* *12686802.3.12*	*IT-1.6* *IT-1.7* *IT-1.10*	*Cholesterol management* *Controlling high blood pressure* *Diabetes care: HbA1c poor control (>9.0%)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 6.1: [I-17.3] Improved access to care coordination in a way that would otherwise not have occurred. Baseline: Number of real time multidisciplinary conferences with health care providers, including e-consultations, family and/or other non-clinical parties in DY2. Goal: Connect providers on 100 qualified conference / referral opportunities (direct consult, store & forward, etc.) Data Source: EHR **Milestone 6 Estimated Incentive Payment: $988,944**	**Milestone 10 [I-17]** Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 10.1: [I-17.3]Improved access to care coordination in a way that would otherwise not have occurred. Baseline: Number provided in DY3. Goal: 10% increase over baseline Data Source: EHR **Milestone 10 Estimated Incentive Payment: $846,353** **Milestone 11** [I-16]: Expand telemedicine-enhanced clinics Metric 11.1[I-16.1]: New telemedicine-enhanced clinics Baseline: Number of UTSW enhanced clinics available during DY 3. Goal: Add 5 Network telemedicine-enhanced clinics over baseline. Data Source: Appointment scheduling software records **Milestone 11 Estimated Incentive Payment: $846,352**	Metric 15.1: [I-18.2] Number of Telemedicine/Telehealth visits Baseline: Number of telemedicine visits provided in DY4. Goal: 100 Telemedicine / Telehealth visits (direct consult, store & forward, etc.) for peer-to-peer consultation, patient evaluation, and specialist referrals above baseline. Data Source: Registry, EHR, claims or other Performing Provider source **Milestone 15 Estimated Incentive Payment: $817,732** **Milestone 16 [I-17]** Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 16.1: [I-17.3] Improved access to care coordination in a way that would otherwise not have occurred. Baseline: Number provided in DY4. Goal: 5% increase over baseline Data Source: EHR **Milestone 16 Estimated Incentive**

126686802.1.4	***PROJECT OPTION*** ***1.7.1***	***PROJECT COMPONENT(S)*** ***1.7.1 (A-B)***	***INTRODUCE, EXPAND, OR ENHANCE TELEMEDICINE/TELEHEALTH***	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measure(s):	*12686802.3.10* *12686802.3.11* *12686802.3.12*	*IT-1.6* *IT-1.7* *IT-1.10*	*Cholesterol management* *Controlling high blood pressure* *Diabetes care: HbA1c poor control (>9.0%)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
				Payment: $817,733
Year 2 Estimated Milestone Bundle Amount: **$3,602,308**	Year 3 Estimated Milestone Bundle Amount: **$3,955,779**		Year 4 Estimated Milestone Bundle Amount: **$4,231,764**	Year 5 Estimated Milestone Bundle Amount: **$ 4,088,661**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***: $15,878,512**				

Project Option 1.9.2 - UT Southwestern Clinical Center: **Establishing a New Community Specialty Care Outreach Center**

Unique Project ID: 126686802.1.5
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW")/126686802

Summary Information
Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds in the St. Paul and Zale Lipshy Hospitals and 40 clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, UTSW physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices.

Intervention(s): This project establishes a new Specialty Care Clinic providing cardiology and other selected specialties to be determined based on demand.

Need for the Project: The Community Needs Assessment for RHP 9 identifies the lack in specialty care capacity, in addition high emergency department utilization for ambulatory conditions, to be areas of particular concern to the Region. UT Southwestern desires to reach out to the community by providing points of access throughout the community. Thus, this project will provide patients with a point of access to UT Southwestern that is in addition to UT Southwestern's main campus.

Target Population: The service area for the clinic is all people living within a 5-mile radius. Approximately 3% of our main campus outpatient population is either Medicaid eligible or indigent, so we expect an increase to 5% to benefit from this increased specialty care capacity. Low income population of service area zip codes ranges from 9% to 27%, with an average of 20%. Patterns of care and population movement suggest that 5% is a reasonable target for this new clinic.

Category 1 or 2 Expected Patient Benefits: The newly established specialty clinic seeks to provide 5,000 patient visits from a panel of 2,000 unique patients by DY5. Patient Visits are projected to grow from 2000 in DY2, 2750 in DY3, to 3500 in DY4, to 5000 in DY5. Unique patients are expected to grow from 500 in DY2, to 1,000 in DY3, 1,500 in DY4, and 2,000 in DY5. Based on demand, office hours are project to grow from an average of 40 hours per week in DY2, to 44 hours in DY3 and 48 hours in DY4.

Category 3 Outcome Measures:

- IT-1.6 Cholesterol Management—Our goal is to increase the number of patients with cardiovascular conditions that have a received an LDL-C test with a measurement of less than 100 mg/dL by X% (TBD) by DY5 over the DY2 baseline.

- IT-1.7 Controlling high blood pressure—Out goal is to increase the number of patients with hypertension whose most recent BP is adequately controlled by X% (TBD) by DY5 over the DY2 baseline.

Project Description

UT Southwestern Medical Center is in the process of establishing a new multispecialty clinic in Dallas County that is comprised of both Specialty Care and Primary Care Services.

This *proposal addresses solely the Specialty Care Clinic components*. The Specialty Care Clinic is planned to provide Cardiology and other selected specialties to be determined based on demand. When the new Clinic opens in January 2013, it will be staffed by at least one Cardiologist. As demand builds, additional specialists will be recruited to the clinic. The Specialty Care Clinic area will offer access to laboratory testing, cardiac stress testing, plain film x-rays and mammography.

The new clinic will have an electronic medical record that immediately will be integrated into the main UT Southwestern electronic medical record system. This will facilitate and increase access to other UT Southwestern specialists, clinics, and sophisticated diagnostic capabilities, as needed. Referrals within the system will be tracked.

The new clinic will require UT Southwestern to recruit additional physicians to the Faculty Practice Plan, which in turn will increase the capacity of UT Southwestern to see more patients. The new location, at Hillcrest Road and Northwest Highway, will make it easier for patients to access the new providers and services. In addition, once the new clinic reaches certain growth projections, evening and weekend hours are planned to further improve access to services.

By providing a new clinic in the Hillcrest/Northwest Highway area, UT Southwestern will be able to increase access to selected specialists at a location that is easier to find and navigate. Parking at the new location is free and easily accessible. Importantly, the location is also accessible by DART bus and train routes. Finally, increasing the number of specialty care providers will reduce the time it takes patients to obtain appointments, which can reduce the time to needed diagnosis and treatment.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals:

The goals of this project are as follows:

- Increase access to selected specialists at a location that is convenient to patients and located close to public transit;
- As demand grows, offer evening and weekend hours;
- Recruit new specialist physicians to practice within the new clinic location; and
- Increase the number of new patients accessing needed specialty care.

This project also meets the following regional goals

RHP 9 has identified capacity and access to appropriate, timely specialty care as one of the major issues facing the region. This project aims to address this issue by increasing access to specialty care and providing high quality, comprehensive specialty care collocated with primary care to patients in a less costly setting—an outpatient clinic. Emergency Department utilization and potentially preventable readmission rates are high in RHP 9. The project meets a regional goal of providing the right care, at the right time, in the right setting.

Challenges

New medical services in new locations face two substantive challenges. First, the community must be made aware of the new clinic and the types of physician services that are available. The second challenge is projecting the appropriate range and level of services to be provided based on demand/need assumptions. A marketing plan is being developed to announce the new Clinical Center that is designed to reach the community using web-based and print-based media targeted at service area referring physicians, households, and local newspapers. Based on the Community Needs Assessment, expanded cardiology services will be provided on a graduated basis and regulated by the response from the service area community. Other Internal Medicine sub-specialties will be evaluated based on patient feedback and community needs.

5-Year expected Outcomes for Provider and Patients:

Within the 5-Year period, we plan to have at least one full-time equivalent cardiologist, in addition to selected other specialists and sub-specialists as demand warrants. The service area for the clinic is all people living within a 5-mile radius. Approximately 3% of our main campus outpatient population is either Medicaid eligible or indigent, so we expect an increase to 5% to benefit from this increased specialty care capacity. Low income population of service area zip codes ranges from 9% to 27%, with an average of 20%. Patterns of care and population movement suggest that 5% is a reasonable target for this new clinic. The newly established specialty clinic seeks to provide 5,000 patient visits from a panel of 2,000 unique patients by DY5. Patient Visits are projected to grow from 2000 in DY2, 2750 in DY3, to 3500 in DY4, to 5000 in DY5. Unique patients are expected to grow from 500 in DY2, to 1,000 in DY3, 1,500 in DY4, and 2,000 in DY5. Based on demand, office hours are project to grow from an average of 40 hours per week in DY2, to 44 hours in DY3 and 48 hours in DY4.

Starting Point/Baseline

This new UTSW Clinical Center is in the fast-track design-build process. The specialty services, initially cardiology, are scheduled to become available in January 2013. Other specialties may be represented depending on demand. As a result of this being a new clinic, the **baseline is zero** for the number of clients served by the project. Projections targeting unique patients and patient visit volumes are still being developed.

The new specialty clinic will require UT Southwestern to recruit new physicians in Cardiology and selected other specialties, such as Oncology, depending upon demand. While we do not contemplate training residents at the new location during the first year, the clinic would provide an ideal setting to train medical students and residents in how to practice in a traditional community setting.

Rationale

UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, UT Southwestern's faculty physician practice is one of the largest providers of physician services to the Medicaid program in Texas. For example, between December 2010 and November 2011, UT Southwestern physicians provided care to Charity and Medicaid patients during 274,498 outpatient visits, of which 16,175 of these outpatient visits were specifically at UT Southwestern practices. Thus, UT Southwestern physician services are directly impacted by the negative outcomes created by inadequate access to specialty care for the patients of RHP 9.

In addition, the RHP 9 Community Needs Assessment Report (April 2012) identifies increasing Primary Care and Specialty Care as first on their list of five priorities. More specifically, it states that "The demand for primary and specialty care services exceeds that of available medical physicians in these areas, thus limiting healthcare access for many low level management or specialized treatment for prevalent conditions. The top five prevalent conditions found in the Emergency Department are conditions that could be better managed in ambulatory clinics rather than hospital Emergency Departments.

In addition, the RHP 9 Community Needs Assessment Report notes that Dallas County has significant HPSA (Health Professions Shortage Areas) and MUA (Medically Underserved Areas). In order to expand capacity, more primary care and specialty care physicians need to be trained and/or recruited to Dallas County. At the same time, these providers need to be distributed more widely with the addition of new clinic sites to improve access by the targeted populations. The new Clinical Center is within commuting distance of several MUA-designated areas. The Community Needs Assessment addresses the need for more access to specialists but there are no designated geographic areas defined.

All patient populations have difficult gaining timely access to primary care physicians and specialists who provide care to patients with complicated or complex medical problems. This new clinic and the new providers address this challenge.

The new UT Southwestern Clinical Center represents a new initiative for UT Southwestern. The new clinic is part of an innovative strategy to create and operate multispecialty clinics away from the main campus. This will result in being able to provide expanded primary care services closer to the communities and populations that want and need improved access to UT Southwestern primary care physicians and specialists. The clinic will be located near several major highways and roads. It is also accessible by the DART System bus and train lines.

By providing a new clinic in the Hillcrest/Northwest Highway area, UT Southwestern will be able to expand primary care and increase access to selected specialists, as well as primary care physicians, at a location that is easier to find and navigate. Increasing the number of primary care providers will reduce the time it takes patients to obtain appointments, which can reduce the time to needed diagnosis and treatment. Furthermore, creating additional access away from the UT Southwestern Medical Center campus will relieve campus congestion and improve access primary care physicians, as well as improving access to the comprehensive spectrum of specialists and diagnostic services on the campus. Effectively, the new clinic improves access to primary care and specialty care in both the new clinic and to the existing clinics on the UT Southwestern campus.

Project components:

Through this project, we propose to meet all the required project components:

a) *Increase service availability with extended hours*

   Once the new clinic is established and growth projections are achieved, evening and weekend hours are planned.

b) *Increase number of specialty clinic locations*

   This project is selected because it will add a new specialty care clinic in the community, increase availability of Cardiology care providers and other selected specialists, improve access to specialty care.

c) *Implement transparent, standardized referrals across the system*

   UT Southwestern currently has the capability through its electronic medical record system. This system will be implemented in the new clinic.

d) Conduct quality improvement for the project using methods such as rapid cycle improvement (Shewhart Cycle: PDSA).

Community Needs Addressed

- CN.3-Healthcare Capacity
- CN.8-Specialty Care
- CN.9-Chronic Disease

- CN.12-Emergency Department Usage and Readmissions

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management:

- IT-1.6: Cholesterol Management (standalone measure)
- IT-1.7: Controlling high blood pressure (standalone measure)

Reasons/rationale for selecting the outcome measures:

The RHP 9 Community Needs Assessment Report (April 2012) identifies the top five prevalent conditions found in the Emergency Department encounters, which include hypertension and diabetes. These are conditions that could be better managed in the continuity of ambulatory clinic settings rather than episodic setting of hospital Emergency Departments. As part of a larger Chronic Disease Management strategy, monitoring indicators that will help prevent complications and slow the progress of the disease are high priorities.

In addition, the annual Behavioral Risk Factor Survey (BRFSS) is a valuable national source of ongoing data regarding the key risk factors for diabetes in Texans 18 years of age or older. High blood pressure, high blood cholesterol levels, and obesity are the top three risk factors associated with diabetes prevalence, heart disorders, and other conditions. Diabetes prevalence in Dallas County is significantly higher than the national average.

Relationship to other Projects

This project relates to all of the other proposed projects in terms of improving access, capacity and performance across all primary care settings. The specific projects include:

126686802.1.1.2 Expand Primary Care Capacity
126686802.1.1.4 Implement evidence-based projects to enhance primary care capacity
126686802.1.7.1 Implement telemedicine program
126686802.2.1.1 Development of PCMH standards
126686802.2.9.1 Develop patient navigation services

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

195018001.1.2 Baylor Medical Center at Carrollton (Trinity)
121790303.1.2 Baylor Medical Center at Garland
121776204.1.2 Baylor Medical Center at Irving
139485012.1.2 Baylor University Medical Center
127295703.1.5 Parkland Health & Hospital System

Learning Collaboratives: We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain

additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criterion rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using the criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). **This project's score for this criteria: 6**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population. **This project's score for this criteria: 6**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues. **This project's score for this criteria: 5.9**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person. **This project's score for this criteria: 4**

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability. **This project's score for this criteria: 4**

6. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability. **This project's score for this criteria: 5**

Total Valuation Score for this project: **5.5**

126686802.1.5	*PROJECT OPTION 1.9.2*	*PROJECT COMPONENT(S) 1.9.2 (A-D)*	*UT Southwestern Clinical Center: Establishing a New Community Specialty Care Outreach Center*	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measures:	*126686802.3.13* *126686802.3.14*	*IT-1.6* *IT-1.7*	*Cholesterol Management for patients with cardiovascular conditions* *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-11]: Launch/expand a specialty care clinic. **Metric 1.1 [P-11.1]:** Establish/expand specialty care clinic. **Baseline:** No previous off-campus UTSW clinic in Dallas County. Documentation of detailed expansion plans. **Goal:** Add one additional specialty care clinic. **Data Source:** Design and construction documents. Lease for new property. Rationale: The national, regional and local supply of specialty care physicians does not meet the demand for specialty care services. Milestone 1 Estimated Incentive Payment: **$575,369** **Milestone 2 [I-22]:** Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted specialties. **Metric 2.1 [I-22.1]:** Increase number of specialist providers, clinic hours, and/or procedure hours in targeted	**Milestone 5 [I-22]:** Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted specialties. **Metric 5.1 [I-22.1]:** Increase number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. **Baseline:** Year 2 will be the baseline period because this is a new clinic. **Goal:** 10% increase in number of hours (4 hours per week). **Data Source**: Clinic documentation of clinic hours **Rationale:** Expanded hours providers more choices for patients and and more allows for more patients to be seen. **Milestone 5 Estimated Incentive Payment: $842,435** **Milestone 6** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for	**Milestone 8 [I-22]:** Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted specialties. **Metric 8.1 [I-22.1]:** Increase number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. Baseline: Year 3 operating schedule will be the baseline period. Goal: Add an additional 4 hours of access per week. Data Source: Clinic documentation of clinic hours Milestone 8 Estimated Incentive Payment: **$1,351,813** **Milestone 9 [I-23**]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 9.1 [I-23.2]:** Documentation of increased number of unique patients, or size of patient panels **Baseline**: Baseline is the number of unique patients in previous year of clinic operations.	**Milestone 10 [I-23]:** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 10.1 [I-23.2]:** Documentation of increased number of unique patients, or size of patient panels **Baseline**: Baseline is the number of unique patients in Year 4 of clinic operations. **Data Source**: EHR and billing reports. **Goal:** Add 25% more patients to panel. **Milestone 10 Estimated Incentive Payment**: **$2,612,200**

126686802.1.5	*PROJECT OPTION 1.9.2*	*PROJECT COMPONENT(S) 1.9.2 (A-D)*	*UT Southwestern Clinical Center: Establishing a New Community Specialty Care Outreach Center*	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measures:	*126686802.3.13* *126686802.3.14*	*IT-1.6* *IT-1.7*	*Cholesterol Management for patients with cardiovascular conditions* *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)**
specialties. **Baseline**: This is a new clinic, therefore, the baseline is zero UTSW providers and staff. **Goal:** Add at least 1 FTE physicians and 3 support staff. **Data Source**: New Specialty Care schedules, Faculty Practice Plan and Human Resources hiring summaries and other related documents. Milestone 2 Estimated Incentive Payment: **$575,369** **Milestone 3 [I-22]:** Increase the number of specialist providers, clinic hours, and/or procedure hours available for the high impact/most impacted specialties. **Metric 3.1 [1-22.1]:** Increase number of specialist providers, clinic hours, and/or procedure hours in targeted specialties. Numerator: Number of clinic hours in targeted specialties over baseline. Denominator: Number of clinic hours in baseline (zero in Year 1). **Goal**: Clinic will operate 40 hours	patients seeking services. **Metric 6.1** [I-23.1]: Documentation of increased number of visits. **Baseline**: Number of visits and procedures in DY2. **Goal**: 25% increase in volume **Data Source**: EHR and billing reports. Milestone 6 Estimated Incentive Payment: **$842,435** **Milestone 7 [I-23]:** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric [I-23.2]:** Documentation of increased number of unique patients, or size of patient panels. **Baseline**: Baseline is the number of unique patients in Year 1 of clinic operations. **Data Source**: EHR and billing reports. **Goal:** 25% increase in volume above previous year. Milestone 7 Estimated Incentive Payment: **$842,434**	**Goal:** 25% increase in volume. **Data Source**: EHR and billing reports. Milestone 9 Estimated Incentive Payment: **$1,351,814**	

126686802.1.5	*PROJECT OPTION 1.9.2*	*PROJECT COMPONENT(S) 1.9.2 (A-D)*	*UT Southwestern Clinical Center: Establishing a New Community Specialty Care Outreach Center*	
The University of Texas Southwestern Medical Center				*126686802*
Related Category 3 Outcome Measures:	*126686802.3.13* *126686802.3.14*	*IT-1.6* *IT-1.7*	*Cholesterol Management for patients with cardiovascular conditions* *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)**
per week. Data Source: EHR data and scheduling and operating documents. **Milestone 3 Estimated Incentive Payment: $575,369** **Milestone 4 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 4.1 [I-23.1]:** Documentation of increased number of visits. **Baseline**: Will be zero because it is a new clinic. **Goal:** 2,000 cardiology visits in the remaining part of Year 2 after clinic opens. **Data Source:** EHR reports. **Milestone 4 Estimated Incentive Payment: $575,368**			
Year 2 Estimated Milestone Bundle Amount**: $2,301,475**	Year 3 Estimated Milestone Bundle Amount: **$2,527,304**	Year 4 Estimated Milestone Bundle Amount: **$2,703,627**	Year 5 Estimated Milestone Bundle Amount: **$2,612,200**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***: $10,144,606**			

Project Option 1.10.2 - Implement UT Southwestern Population Management Infrastructure Development

RHP Project Identification Number: 126686802.1.6
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW") Faculty Practice Plan /126686802

Summary Information

Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 40 hospital-based and ambulatory-based clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, UTSW physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices.

Intervention(s): This project will create a population management infrastructure that will enhance improvement capacity through technology, and allow the measuring, reporting and driving of quality improvement.

Need for the Project: UT Southwestern does not have the current technological capability for predictive modeling, patient risk stratification, or access to point-of-care tools. Thus, the ability to manage and track UTSCAP Network patient outcomes across the Network does not exists, resulting in an inability to provide the most efficient, quality care in the right setting at the right time.

Target Population: The target population for project is all patients seen within the UTSCAP Network (our patients). Approximately 3% of our patients are either Medicaid eligible or indigent, so we expect 3% to benefit from this increased primary care capacity.

Category 1 or 2 Expected Patient Benefits: The project seeks to increase collection of quality measure data, increase the number of reports generated through quality management data systems and increase the submission of quality dashboard/scorecards throughout UTSW by 10% in DY5 above the DY2 baseline. Patients are expected to benefit by reduced duplicative testing, reduced readmissions and better health via the project's systematic reporting of quality indicators. UTSW will substantially add to the number of patients in RHP 9 that have access to high quality, integrated care that has historically been unavailable. We anticipate by DY5 that approximately 277,000 covered lives, including 44,000 Medicaid/low income patients, will benefit from this program. We expect these patient populations to benefit from 1,100,000 patient contacts, including 178,000 Medicaid contacts, regarding their health and ways to improve their health as a result of the development and implementation of this program.

Category 3 Outcome Measures:

- IT-1.10 Diabetes Care: HbA1c— Out goal is to decrease the number of patients with diabetes who had a HbA1c greater than 9.0% by X% (TBD) by DY5 over the DY2 baseline.

- IT-12.1 Breast Cancer Screening—Our goal is to increase the number of women aged 40 to 69 that have received an annual mammogram by X% (TBD) by DY5 over the DY2 baseline.

- IT-12.3 Colorectal Cancer Screening—Out goal is to increase the number of adults aged 50 to 75 that have received colorectal cancer screening by X% (TBD) by DY5 over the DY2 baseline.

- IT-12.4 Pneumonia Vaccination Status of Older Adults—Out goal is to increase the number of patients who are older adults receiving a pneumonia vaccination by X% (TBD) by DY5 over the DY2 baseline.

Project Description

UT Southwestern proposes to create a population management infrastructure that will enhance improvement capacity through technology, allow the measuring, reporting and driving of quality improvement.

This population management infrastructure will be implemented in the UT Southwestern Clinical Affiliates Program (UTSCAP) Network. The UTSCAP Primary Care Network (the "Network") is designed to integrate community-based primary care physicians and the faculty physicians of UT Southwestern Medical Center ("UT Southwestern"). The Network is in an early stage of development and growth. It is actively recruiting community-based primary care physicians and their practices to join UT Southwestern faculty physicians. The ultimate goal of the Network is delivering patient care at the highest level of quality by the most cost-effective means, achieved through the clinical integration of Network physicians. Such outcomes are good for patients, payors, physicians and the community. The specific short and long-term objectives for the Network include:

- Expanding access to primary care resources for RHP 9 patient population;
- Expanding, strengthening and implementing a clinically integrated network;
- Creating and implementing a quality care model that will most efficiently utilize finite primary care resources for patients of RHP 9;
- Developing an infrastructure for effective care coordination of Network patients;
- Enhancing and continually developing a clinically integrated organizational structure in preparation of health care reform and value-based reimbursement; and

Advancing the use of technology to improve health care and reduce medical errors.

This project will take critical steps towards linking existing silos of information to improve quality and efficiency. UT Southwestern will utilize innovative tools and programs to evaluate the use of resources, measure the value to patients, compare and contrast to other like providers, and attempt to eliminate wasteful spending.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals

The goal of this project is to implement process improvement methodologies and systems to improve safety, quality, and efficiency. Through UT Southwestern's population management infrastructure investments, we intend to accomplish the following:

- Develop and implement a program of continuous improvement that will increase communication;
- Integrate system workflows;
- Provide actionable data to providers;
- Identify and attempt to reduce inefficiencies and waste;
- Facilitate the flow of patients and information;
- Enhance quality, drive down cost; and
- Identify and improve models of patient-centered care that address issues of safety, quality, and efficiency.

This project also meets the following regional goals:

A major goal of the region is to provide the right care, at the right time, in the right setting in an effort to reduce unnecessary emergency department and hospital utilization. This project would contribute to achieving that goal by providing Network physicians with the tools necessary to accomplish this goal. In addition, emergency department utilization is high in RHP 9 and by improving the quality of care patients receive through the Network, this project helps achieve the regional goal to keep patients from unnecessarily using the emergency departments and urgent care centers as a means to receive basic care.

Challenges

In today's healthcare environment there continues to be a serious lack of communication and electronic linkages amongst providers, a lack of quality performance data, infrequent data mining, and relatively little prospective analysis. Due to the costs associated with the

development of this infrastructure, the complexities associated with establishing these links, and the economic realities of healthcare, the provider community has historically not optimized investments in this type of infrastructure. As a result, the challenge for UT Southwestern will be developing an environment where providers recognize the benefits associated with population management infrastructure and embrace the required changes to improve the quality and cost efficiency for all patient populations.

UT Southwestern intends to overcome these obstacles by making the investments necessary to enhance provider connectivity. In fact, a pre-requisite of community-based primary care physicians to joining the UTSCAP Network is agreeing to electronically connect to UT Southwestern faculty physicians. As outlined in other UT Southwestern DSRIP projects, an important part of the solution will be to help offset the cost of these infrastructure investments.

5-Year expected outcomes for providers and patients

Through the implementation of this project, the 5-year expected outcomes include improved quality and adoption of efficiency principles, better analytic and forecasting capability, enhanced performance improvement capabilities, substantially improved quality data measurement, and improved physician reporting throughout the Network. The anticipated outcome for patients will be reduced duplicative testing, reduced readmissions, improved provider handoffs, and a higher compliance with evidence-based criteria. UTSW will substantially add to the number of patients in RHP 9 that have access to high quality, integrated care that has historically been unavailable. We anticipate by DY5 that approximately 277,000 covered lives, including 44,000 Medicaid/low income patients, will benefit from this program. We expect these patient populations to benefit from 1,100,000 patient contacts, including 178,000 Medicaid contacts, regarding their their health and ways to improve their health as a result of the development and implementation of this program.

Starting Point/Baseline

UT Southwestern has a robust electronic medical record system in both its inpatient and outpatient facilities. However, UT Southwestern does not have the current technological capability for predictive modeling, patient risk stratification, or access to point-of-care tools. In addition, for the UTSCAP Network clinics that are community based, despite having an electronic medical record, the ability to manage and track Network patient outcomes across the Network does not exist. Thus, the starting point for this initiative, prior to December 1, 2011, is zero (0).

Rationale

UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, UT Southwestern's faculty physician practice is one of the largest providers of physician services to the Medicaid program in Texas. For example, between December 2010 and November 2011, UT Southwestern physicians provided care to Charity and Medicaid

patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices. Thus, UT Southwestern physician services are directly impacted by the negative outcomes created by inefficient, ineffective care delivery.

UT Southwestern views performance improvement and reporting as foundational to the success of virtually all health reform initiatives. Quality health care is defined as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." The development of capabilities contained in this project is critical for UT Southwestern to be able to implement process improvement methodologies across the UTSCAP Network to improve safety, quality and efficiency.

UT Southwestern selected this project because it is essential to improving the quality and cost efficiency of caring for our patient population. Without this infrastructure, expanding primary care would increase access but contribute to the inefficient use of resources. Expanding medical homes would be substantially less effective. Coordinating patient care for chronic care management would be nearly impossible. Reducing unnecessary referrals, admissions, readmissions, procedures, and testing would be substantially less effective. Communicating with other providers and coordinating patient care amongst other providers would be severely hampered, and aligning providers via a contracting strategy and quality incentive program would be impractical.

Processes that are inefficient and variable, changing case mix of patients, health insurance, differences in provider education and experience, and numerous other factors contribute to the complexity of health care. The aims of effectiveness and safety are targeted through process-of-care measures, assessing whether providers of health care perform processes that have been demonstrated to achieve the desired aims and avoid those processes that are predisposed toward harm. The goals of measuring health care quality are to determine the effects of health care on desired outcomes and to assess the degree to which health care adheres to processes based on scientific evidence or agreed to by professional consensus and is consistent with patient preferences.

Since errors are caused by system or process failures, it's important to implement various tools and programs to identify inefficiencies, ineffective care, and preventable errors to then influence changes in care processes. Each of these techniques involves assessing performance and using findings to inform change.

Project components

To accomplish UT Southwestern's ultimate goal of implementing process improvement methodologies and systems to improve safety, quality, and efficiency, this project includes the following core elements:

1) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture,
2) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement, and
3) Design data collection systems to collect real-time data that is used to drive continuous quality improvement.

UT Southwestern has selected a number of milestones and metrics that are relevant to the community needs and priorities of RHP 9.

Community Needs Addressed:

The specific and unique community need identification numbers that this project addresses include the following:

- CN.2-Regional Healthcare Infrastructure and Patient migration Patterns
- CN.9-Chronic Disease
- CN.11-Patient Safety and Quality
- CN.12-ED Usage and Readmissions

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

We think this will represent a substantial enhancement over the current delivery system by helping the UTSCAP Network of care teams actively manage patients with targeted chronic conditions, which should improve rates of preventive care. Having the functionality in as many sites as possible will enable care coordination for patients as they access various services throughout the system. These enhancements will allow the Network to better target clinical conditions/diseases most pertinent to the RHP 9 patient population (e.g., diabetes, hypertension, chronic heart failure).

Related Category 3 Outcome Measure(s)

OD-1 Primary Care and Chronic Disease Management

- IT-1.10 Diabetes Care: HbA1c poor control (>9.0%)

OD-12 Primary Care and Primary Prevention Outcomes:

- IT-12.1 Breast Cancer Screening (HEDIS 2012)
- IT-12.3 Colorectal Cancer Screening (HEDIS 2012)
- IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012)

Reasons/rationale for selecting the outcome measures

Our development and implementation of a population management infrastructure available throughout the UTSCAP Network is aimed at increasing the likelihood of desired health outcomes. We selected the above outcomes because measuring, reporting and acting upon quality improvement measures for primary care should result in the increased incidence of preventative services actually delivered to patients. We subscribe to the theory that screening programs should lead to a cost-effective reduction in disease burden. UT Southwestern will focus on these outcomes for all our attributed patients, irrespective of their socioeconomic status. As a result, we believe focusing on these outcomes will make a measurable difference for individuals in RHP 9 at all income levels.

In addition, we selected the outcome measure of HbA1c because 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. RHP 9 has similar opportunity to benefit from improvements in identifying and managing patients with this condition.

While the ultimate goal of this initiative is implementing process improvement methodologies and systems to improve safety, quality, and efficiency, we selected diabetes care as our outcome measure because of the prevalence of diabetes in our region. UT Southwestern will be focusing on this outcome for all our attributed patients, irrespective of their socioeconomic status. As a result, we believe focusing on this outcome will make a measurable difference for individuals in RHP 9 at all income levels.

Relationship to other Projects

The success of this initiative is highly dependent on the implementation of a number of other UT Southwestern DSRIP Projects. Likewise, developing this foundation will be critical to the success of most of the other projects included in the UT Southwestern RHP program. The success of this project is highly dependent on the implementation of the following other projects proposed by UT Southwestern:

- ***126686802.1.1.2—Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics***

- ***126686802.1.1.4—Implement a Quality Incentive Program for Network Primary Care Providers***

- ***126686802.2.1.1—Expanding the Medical Home Model in the UTSCAP Primary Care Network:***

- ***126686802.2.9.1—Implement/Expand Care Coordination Programs***

- ***126686802.2.12.1—Expanding Care Transition Programs***

Relationship to Other Performing Providers' Projects

Parkland Health & Hospital System has a related project for performance improvement (127295703.1.4)

Plan for Learning Collaborative

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the criteria listed below as being most significant to differentiate between projects. Second, we began with a 5-point scale for each criterion rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using the criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

This project's score for this criteria: 3.5 X 2 = 7

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

This project's score for this criteria: 3.5 X 2 = 7

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues. **This project's score for this criteria: 2.5 X 2 = 5**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person. **This project's score for this criteria: 3.5 X 2 = 7**

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 3.5 X 2 = 7

Total Valuation Score for this project: **6.5**

These values are provided for in the table below and are allocated equally amongst the milestones.

126686802.1.6	*PROJECT OPTION* *1.10.2*	*PROJECT COMPONENT(S)* *1.10.2(a-c)*	***Develop Population Management Infrastructure***	
UT Southwestern Medical Center Faculty Practice Plan				*126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.15*	*IT-12.1*	Breast Cancer Screening	
	126686802.3.16	*IT-12.3*	Colorectal Cancer Screening	
	126686802.3.17	*IT-12.4*	Pneumonia vaccination status for older adults	
	126686802.3.18	*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-1]: Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the Performing Provider's delivery system Metric 1 [P-1.1]: Documentation of the establishment of performance improvement office Baseline: No Population Management PI office Goal: Documentation of establishment of office Data Source: HR documents, office policies and procedures **Milestone 1 Estimated Incentive Payment: $900,577** **Milestone 2 [P-1]:** Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activitiesacross the Performing Provider's delivery system Metric 1 [P-1.2]: Documentation that	**Milestone 4 [P-6]:** Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends) Metric 1 [P-6.1]: Increase number of staff trained in quality and efficiency improvement principles Numerator: Number of staff trained Denominator: Total number of staff Baseline: Zero (0). Goal: Train 1 or more staff. Data Source: HR, training programs **Milestone 4 Estimated Incentive Payment: $593,367** **Milestone 5 [P-6]:** Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends)	**Milestone 9 [P-6]:** Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends) Metric 1 [P-6.1]: Increase number of staff trained in quality and efficiency improvement principles Numerator: Number of staff trained Denominator: Total number of staff Baseline: 1 trained staff Goal: Train 2 staff beyond baseline. Data Source: HR, training programs **Milestone 9 Estimated Incentive Payment: $528,971** **Milestone 10 [P-6]:** Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends)	**Milestone 15 [P-6]:** Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends) Metric 1 [P-6.1]: Increase number of staff trained in quality and efficiency improvement principles Numerator: Number of staff trained Denominator: Total number of staff Baseline: 3 Goal: Train 1 or more staff beyond baseline. Data Source: HR, training programs **Milestone 15 Estimated Incentive Payment: $511,083** **Milestone 16 [P-6]:** Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and

126686802.1.6	*PROJECT OPTION* *1.10.2*	*PROJECT COMPONENT(S)* *1.10.2(a-c)*	***Develop Population Management Infrastructure***	
UT Southwestern Medical Center Faculty Practice Plan				*126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.15* *126686802.3.16* *126686802.3.17* *126686802.3.18*	*IT-12.1* *IT-12.3* *IT-12.4* *IT-1.10*	Breast Cancer Screening Colorectal Cancer Screening Pneumonia vaccination status for older adults 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)**
the performance improvement office is engaged in collecting, analyzing, and managing real-time data (examples could include weekly run charts or monthly dashboards). Baseline: Not collecting or analyzing population management performance improvement data. Goal: Documentation of collecting and analyzing performance data. Data Source: Network data **Milestone 2 Estimated Incentive Payment: $900,577** **Milestone 3 [P-5]:** Enhance or expand the organizational infrastructure and resources to store, analyze and share the patient experience data and/or quality measures data, as well as utilize them for quality improvement. Metric 1 [P-5.1]: Increased collection of patient experience and/or quality measures data. Baseline: No Population Management infrastructure or quality measures data Goal: Ehanced data collection by	Metric 1 [P-6.2]: Increase number of data analysts hired who are responsible for collecting and analyzing real-time data to measure improvement and trends and to drive rapid performance improvement. Baseline: Zero (0). Goal: Hire an analyst. Data Source: HR, training programs **Milestone 5 Estimated Incentive Payment: $593,367** **Milestone 6 [P-5]**: Enhance or expand the organizational infrastructure and resources to store, analyze and share the patient experience data and/or quality measures data, as well as utilize them for quality improvement. Metric 1 [P-5.1]: Increased collection of quality measures data. Baseline: Amount of quality measure data collected in CDR in DY2. Goal: 10% increase in quality data collected and utilzation of population risk stratification infrastructure.	Metric 1 [P-6.2]: Increase number of data analysts hired who are responsible for collecting and analyzing real-time data to measure improvement and trends and to drive rapid performance improvement. Baseline: 1 analyst Goal: Hire 1 analyst above baseline. Data Source: HR, training programs **Milestone 10 Estimated Incentive Payment: $528,971** **Milestone 11 [I-7]**: Implement quality improvement data systems, collection, and reporting capabilities Metric 1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems. Baseline: 20 QI reports Goal: 20 QI reports above baseline Data Source: Quality improvement data systems **Milestone 11 Estimated Incentive Payment: $528,971**	analytics staff for reporting purposes (e.g., to measure improvement and trends) Metric 1 [P-6.2]: Increase number of data analysts hired who are responsible for collecting and analyzing real-time data to measure improvement and trends and to drive rapid performance improvement. Baseline: 2 analysts Goal: Hire 1 analyst above baseline. Data Source: HR, training programs **Milestone 16 Estimated Incentive Payment: $511,083** **Milestone 17 [I-7]**: Implement quality improvement data systems, collection, and reporting capabilities Metric 1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems. Baseline: 40 QI reports Goal: 20 QI reports above baseline. Data Source: Quality improvement data systems

126686802.1.6	*PROJECT OPTION* *1.10.2*	*PROJECT COMPONENT(S)* *1.10.2(a-c)*	***Develop Population Management Infrastructure***	
UT Southwestern Medical Center Faculty Practice Plan				*126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.15* *126686802.3.16* *126686802.3.17* *126686802.3.18*	*IT-12.1* *IT-12.3* *IT-12.4* *IT-1.10*	Breast Cancer Screening Colorectal Cancer Screening Pneumonia vaccination status for older adults 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)**
installing CDR infrastructure. Data Source: Documentation of quality measures data collection and reporting. **Milestone 3 Estimated Incentive Payment: $900,577**	Data Source: Documentation of quality measures data collection and reporting. **Milestone 6 Estimated Incentive Payment: $593,367** **Milestone 7 [I-7]**: Implement quality improvement data systems, collection, and reporting capabilities. Metric 1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems. Baseline: Zero (0) QI reports generated. Goal: 20 QI reports generated Data Source: Quality improvement data systems. **Milestone 7 Estimated Incentive Payment: $593,367** **Milestone 8 [I-8]**: Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that		**Milestone 12 [I-8]**: Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures. Metric 1 [I-8.1]: Submission of quality dashboard or scorecard. Baseline: 20 quality dashboards Goal: 20 quality dashboards above baseline Data Source: Quality improvement data systems. **Milestone 12 Estimated Incentive Payment: $528,970** **Milestone 13 [I-9]**: Demonstrated improvement in X number of selected quality measures. Metric 1 [I-9.1]: Improvement in selected quality measures. Baseline: Zero (0) selected quality measures Goal: Improvement in 3 selected quality measures.	**Milestone 17 Estimated Incentive Payment: $511,083** **Milestone 18 [I-8]**: Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcomes measures. Metric 1 [I-8.1]: Submission of quality dashboard or scorecard. Baseline: 40 quality dashboards Goal: 20 quality dashboards above baseline Data Source: Quality improvement data systems **Milestone 18 Estimated Incentive Payment: $511,083** **Milestone 19 [I-9]**: Demonstrated improvement in X number of selected quality measures. Metric 1 [I-9.1]: Improvement in selected quality measures. Baseline: 3 quality measures Goal: Improvement in 5 selected quality measures.

126686802.1.6	*PROJECT OPTION* *1.10.2*	*PROJECT COMPONENT(S)* *1.10.2(a-c)*	***Develop Population Management Infrastructure***	
UT Southwestern Medical Center Faculty Practice Plan				*126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.15* *126686802.3.16* *126686802.3.17* *126686802.3.18*	*IT-12.1* *IT-12.3* *IT-12.4* *IT-1.10*	Breast Cancer Screening Colorectal Cancer Screening Pneumonia vaccination status for older adults 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)**
	includes outcome measures and patient satisfaction measures. Metric 1 [I-8.1]: Submission of quality dashboard or scorecard. Baseline: Zero (0) quality dashboards. Goal: 20 quality dashboards. Data Source: Quality improvement data systems. **Milestone 8 Estimated Incentive Payment: $593,367**		Data Source: Quality improvement data systems. **Milestone 13 Estimated Incentive Payment: $528,970** **Milestone 14 [I-10]**: Enhance performance improvement and reporting capacity. Metric 1 [I-10.1]: Increase the number of reports generated through these quality improvement data systems. Baseline: Zero PI reports generated. Goal: 25 PI reports generated. Data Source: Quality improvement data systems. **Milestone 14 Estimated Incentive Payment: $528,970**	Data Source: Quality improvement data systems. **Milestone 19 Estimated Incentive Payment: $511,082** **Milestone 20 [I-10]**: Enhance performance improvement and reporting capacity. Metric 1 [I-10.1]: Increase the number of reports generated through these quality improvement data systems. Baseline: 25 PI reports generated Goal: 10 PI reports generated over baseline. Data Source: Quality improvement data systems. **Milestone 20 Estimated Incentive Payment: $511,082**
Year 2 Estimated Milestone Bundle Amount: **$2,701,731**	Year 3 Estimated Milestone Bundle Amount: **$2,966,835**		Year 4 Estimated Milestone Bundle Amount: **$3,173,823**	Year 5 Estimated Milestone Bundle Amount: **$3,066,496**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: **$11,908,885**				

Project Option: 1.2.1 – Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement.
Title of Project: UT Southwestern Office of CME Initiative: Increasing CME Training of Primary Care Physicians
RHP Project Identification Number: 126686802.1.7 (Pass 2)
Performing Provider Name/TPI: UT Southwestern Medical Center/ TPI 126686802

Summary Information
Summary Description: UT Southwestern Medical Center (UTSW) proposes to develop a significant number of CME and MOC courses for primary care physicians and supporting clinical professionals across the region to better prepare them for participation in DSRIP Program projects. The course topics would include Patient-Centered Medical Home, Chronic Disease Management, Culturally Competent Care, using Telemedicine to improve their practice, Practice Performance Improvement, Medication Management, Disease Prevention, and other topics relevant to the RHP Community Needs Assessment.

Intervention: UTSW Office of CME will significant expand the volume of continuing medical education offerings with relevant DSRIP topic content targeted to primary care providers in the Region, particularly providers providing services to Medicaid and low-income populations. In addition, the CME will be offered in a variety of modalities, from live conferences and symposia, grand rounds, and live webinars, to on-demand on-line webinars and on-line courses, as well as on-site hands-on training and consultations. CME is the ideal opportunity to provide training and education because it is a basic, conditioned obligation of all providers to maintain their license to practice.

Need for project: A great many behavior change and practice pattern alterations are being asked of the primary care providers in Region 9. The many project options and suggested milestones/metrics will require knowledge and skills that generally are not present in the primary care providers at sufficient levels to allow for success of the delivery system reform goals. Adult behavior change at the proposed magnitude suggested in the DSRIP Program necessitates someone providing the requisite education and training opportunities to the entire population of providers in the Region.

Target Population: According to data from The Texas Department of State Health Services, there are 2,512 primary care physicians in Region 9. We are focusing on all primary care providers in the Region, particularly those who serve Medicaid and low-income populations. 24% of physicians in Dallas County accept all Medicaid patients who present, while 21% only accept a limited number. 44% of physicians do not accept Medicaid. All primary care providers will benefit from the targeted CME and MOC programs focusing on the targeted topics.

Category 1 and 2 Expected Benefits: At least 22 new CME programs will be developed across multiple modalities for the 2,512 primary care physicians and approximately 10,000 clinical

professionals who support their patients within the Region, which are affordable and more accessible. The number of attendees for all modalities could easily approach 25,000 by DY5. The new programs will provide a convenient platform for providers to acquire the knowledge and skills to adapt and thrive in the delivery system reform programs being mandated across the Region and Texas, particularly those service Medicaid and low income populations.

Category 3 Outcomes: OD-1: Primary Care and Chronic Disease Management,
IT-1.20: Educated Primary Care Workforce.

Project Description:

UT Southwestern Medical Center (UTSW) proposes to develop a significant number of CME courses for primary care physicians across the region to better prepare them for participation in DSRIP Program projects. The course topics would include Patient-Centered Medical Home, Chronic Disease Management, Culturally Competent Care, using Telemedicine to improve their practice, Practice Performance Improvement, Medication Management, Disease Prevention, and other topics relevant to the RHP Community Needs Assessment. The UTSW Office of CME and Public Education at UT Southwestern Medical Center currently provides a wide range of CME to all physician specialties. Physicians across the region can access educational programs through attendance at Ground Rounds, live conferences and symposia, live webinars, on-demand webinars, on-demand on-line programs. The expansion of the CME programs will include in-office, on-site education programs and consultations. A particular focus for promoting and offering relevant programs will be to providers and their staff who treat Medicaid and low-income patients, particularly if they are in HPSAs and MUAs.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals of the Project and Relationship to Regional Goals:

The goal of expanding the type and accessibility of CME programs to primary care providers, particularly those who deal with Medicaid and low-income populations, is to prepare them to understand, implement, and participate in the delivery system reform initiatives that will improve care to the target populations, reduce costs, and improve outcomes. With adequate education, understanding, and preparation, primary care providers will be much more likely to embrace the kinds of behavior and practice changes that are fundamental to transforming how the deliver services to their patients. Absent adequate knowledge and skills, basic acceptance of proposed delivery system changes and the likely level of success will be inadequate to achieve the goals of the 1115 Waiver and Transformation initiatives. Regional goals across Texas propose to achieve substantive improvements in many areas. There is nothing in the Community Needs Assessments that propose to prepare providers to make the many significant reforms expected of them. This project proposes to remedy that gap by offering accessible and affordable CME, in many different ways, to improve provider understanding, acceptance, and ability to implement the proposed reforms.

Challenges:

Many studies have look how difficult it is to change behavior in adults. The DSRIP Program's goals set challenging timeframes to achieve behavior change and to measurably impact the costs of care and the outcomes of transformed services. The challenge will be providing sufficient educational resources in a timely manner to prepare enough primary care providers across the region to be successful in reforming how they deliver care. To meet that challenge, the UTSW Office of CME will offer an expanded menu of course content relevant to the Region's goals. UTSW will offer CME in a variety of ways to make it affordable and more accessible to all primary care providers regardless of the schedules and busy practices. The courses will be offered through live conferences, webinars, on-demand on-line programs, and in-office consultations for hands-on education.

5-Year Expected Outcomes for Provider and Patients:

By the end of DY5, there will be a significant increase in the knowledge and skills of the primary care provider workforce across the Region as demonstrated in pre-CME and post-CME evaluations. This project will support almost all regional goals by insuring that primary care providers have acquired the knowledge and skills to accommodate the behavioral changes needed to transform their delivery behaviors. According to data from The Texas Department of State Health Services, there are 2,512 primary care physicians in Region 9. The DY2 will determine how much education is taking place among the Region's primary care providers relevant to the region's goals. The planned outcome is to have the region's primary care providers participating in relevant CME programs of one kind or another, with demonstrated improvements in knowledge and skills. New courses will be added to address the particular needs of healthcare transformation in RHP 9: 4 new courses in DY2, 6 new courses in DY3, 6 more new courses in DY4 and DY5, for a total increase of 22 new courses. It is important to note that members of the primary care provider team, including physicians, mid-level providers, nurses, physical therapists, and other, particularly if they serve Medicaid and low income populations, have the biggest challenge affording the expense and the time to attend CME and MOC programs. The project will have a substantial focus on developing CME and MOC opportunities for webinars, on-demand courses, and long distance options at lower cost than live seminars and conferences. While CME is only one factor in transforming the Region's delivery system, it is an essential one. PCPs who are now or who will be caring for Medicaid patients desperately need the skills and knowledge offered by these new programs. Medicaid patients will benefit from their providers knowing how to better manage their health problems. For patients, the outcomes will be reflected in the progress that primary care providers have made due to their acquired knowledge and skills.

Starting Point/Baseline:

During the first year of the project (DY2), UTSW hired a new AVP for the Office of Continuing Medical Education. UTSW will conduct surveys to determine the extent to which the Region's primary care providers are participating in CME and MOC relevant to the identified needs providing primary care providers in the community with the knowledge and skills related to developing and participating in patient-centered medical homes and chronic care models, disease registry use for population management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement. The results of this

survey will establish the baseline of participation and course content. The results also will help determine the resources that will be needed to improve the understanding and skills of primary care providers through expanding courses offerings and means of accessing them. At least 22 new courses will be developed beginning in DY2 and expanded through DY5 based on need and demand.

Rationale:

The Community Needs Assessment and the Project Options address the shortage of primary care providers and the need to train more of them. Many of the projects address the need to plan, develop and implement a dizzying array of new initiatives. All of these documents appear to assume that the providers and their staffs already have the knowledge and skills to carry out the new initiatives OR that all of these implementation plans include training and orientation of the existing provider population. The literature abounds with articles, studies and research outcomes showing the lack of understanding for how to carry out many of the new delivery system tactics. There is ample research to show that adult behavior change takes time, training, education and reinforcement to be successful. Most Performing Providers have some degree of internal resources that provide orientation, training and continuing education for their employees. The educational content that they offer is what they have correctly determined is the minimum requirements for their respective organizations to be successful. Very few of these organizations have the resources to add significant new content. More importantly, most of the primary care providers dealing with the Medicaid and low-income populations practice outside the walls of the Performing Providers. How, then, will the Region educate, train, and guide community primary care providers in gaining the knowledge and skills needed to participate in such initiatives as Patient-Centered Medical Home, Chronic Disease Management on a population-based model, and Care Coordination across multiple levels of care delivery? The opportunity lies in the hours of continuing medical education that all primary care providers are required to obtain as a requirement of their licensure. CME is not an optional exercise. It makes sense to offer CME that will both meet the requirements of licensure, as well as meet the needs of the healthcare reform imperatives engraved in the Delivery System Reform Incentive Payment Program. UT Southwestern's Office of CME has the leadership, skills, and resources to expand their current scope of educational program content to help prepare primary care providers, in the Region 9 and beyond, for the necessary behavior and practice changes.

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

UT Southwestern already has an Office of CME and Public Education that provides education services. However, the programs and resources are primarily focused on meeting the needs of the UT Southwestern faculty, residents, fellows, medical school and allied health school students. Meeting the needs of community primary care physicians and other providers on the primary care team is an important but secondary focus. The project proposes to expand their focus on primary care providers with a significant expansion of the number of educational offerings with new content addressing the topics essential to the success of the DSRIP Program.

Community Needs Addressed:

Two of the five priorities identified in the RHP 9 Community Needs Assessment are Primary Care Capacity and Chronic Disease Management. The Community Needs specifically addressed by the project, due to the nature of continuing medical education, include:

CN.3 Healthcare Capacity
CN.4 Primary Care
CN.6 Behavioral Health and Primary Care
CN.8 Chronic Disease
CN.11 Patient Safety and Quality
CN.12 Emergency Department Usage and Readmissions
CN.13 Palliative Care

Projects being proposed across RHP 9 include developing or expanding use of the Patient-Centered Medical Home and developing or expanding use of various Chronic Disease Management approaches. These and other projects will require additional knowledge and skills, along with changes to how physician practices are managed. Evidenced-based education and the resultant behavior changes are a significant undertaking. At the same time, if we don't educate and train existing primary care workforces, our ability to implement innovative PCMH and Chronic Disease Management programs will be severely limited. Targeted CME programs will improve the value of the current primary care workforce while we are also working to expand that workforce.

Related Category 3 Outcome Measure(s):

OD-1: Primary Care and Chronic Disease Management

- **Measure IT-1.20: Educated Primary Care Workforce (standalone measure)**

This custom Category 3 Outcome Measure is important to the success of all projects relating to Primary Care and Chronic Disease Management, both of which a in the five priorities listed in the RHP 9 Community Needs Assessment. In order to transform the healthcare delivery system, Performing Providers must prepare, educate and train the existing primary care workforce. The training must be targeted in new areas of continuing medical education. The critical outcome is the demonstration of data that shows the workforce has increased the knowledge and understanding of how to carry out the priority projects identified in the RHP Planning Protocol, which includes understanding and implementing medical home models and chronic disease management models, and other topics important to the RHP. The Category 1 project of developing and providing CME programs with many alternative delivery methods is an essential tool for preparing the workforce and implementing the programs. There is ample evidence showing that the use of appropriate adult education techniques improves the learning and application of new information that can transform how primary care providers deliver care.

Relationship to other Projects:

This project is directly related to the following projects because this project provides the education and training that will assist primary care providers to understand and support implementation of them:

- 126686802.1.2 Expand Primary Care Capacity
- 126686802.1.4 Develop Telemedicine
- 126686802.1.6 Develop Population Management Infrastructure
- 126686802.1.8 Implementing Family Medicine Residency Courses in PCMH, CDM
- 126686802.1.10 Training Community Health Workers
- 126686802.2.1 Enhance/expand Medical Homes
- 126686802.2.2 Apply Process Improvement Methodology
- 126686802.2.4 Establish/Expand a Patient Navigation Program
- 126686802.2.5 Implement/Expand Care Transition Program
- 126686802.2.11 Conduct Medication Management

Relationship to Other Performing Providers' Projects in the RHP: No other project in RHP 9 proposes to provide education and training through CME to community primary care providers.

Plan for Learning Collaborative: The Anchor plans to develop and facilitate Learning Collaboratives in the Region with DFW Hospital Council. UT Southwestern will participate in the Collaborative(s) as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation:

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-

point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criterion:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

This project's score for this criterion: 7.00

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

This project's score for this criterion: 6.00

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criterion: 6.90

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criterion: 4.95

6. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criterion: 4.50

Total Valuation Score for this project: **5.70**

❖ This project is not funded through collaboration funding.

[Unique Category 2 Project Identifier] **126686802.1.7**	*[Reference number of Project Option from RHP PP]* **1.2.1**	*[Reference Number of Project Component(s) from RHP PP -* ***N/A***	***UT Southwestern: UT Southwestern Office of CME Initiative:*** **Increasing CME Training of Primary Care Physicians**	
[RHP Performing Provider involved with this project - Name] ***Faculty Practice Plan at UT Southwestern Medical Center***				**126686802**
Related Category 3 Outcome Measure(s):	**126686802.3.29**	**IT-1.20**	**Educated Primary Care Workforce**	
Year 2 **(10/1/2012 – 9/30/2013)**		**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 (P.1): Conduct a primary care gap analysis to determine workforce needs. **Metric 1.1 (P-1.1):** Gap assessment of workforce shortages. **Baseline/goal**: Submit written assessment on the CME and MOC needs of the primary care providers relating to targeted topics. **Data Sources**: Research on current CME offerings; survey of PCP's CME needs. **Rationale**: Will determine scope of new CME and MOC content and potential demand for offerings. **Milestone 1 Estimated Incentive Payment**: $449,435 **Milestone 2 (P-2):** Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists. **Metric 2.2 (P-2.2):** Hire additional		**Milestone 5(I-11):** Increase primary care training. **Metric 5.1 (P-11.1):** Increase number of primary care course class size. Baseline/goal: Increase overall attendance by 20% over DY2. Data Source: Program materials and enrollment records. **Milestone 2 Estimated Incentive Payment:** $393,580 **Milestone 6 (I-11):** Improvement in trainee satisfaction with specific elements of the training program. **Metric 6.1 (P-11.5):** Trainee satisfaction scores. Numerator: Sum of trainee/enrollee satisfaction scores. Denominator: Total number of trainees/enrollees. Data Source: Satisfaction assessment tool. Rationale: Regular assessment of trainee/enrollee satisfaction is critical to adapting programs to address needs. **Milestone 6 Estimated Incentive**	**Milestone 10 (P-2):** Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists **Metric 10.1 (P-2.2):** Hire additional precepting primary care faculty members/CME staff. Documentation: Increased number of additional training faculty/staff members. Baseline/goal: Add up to two (2) faculty members/CME staff to begin developing, offering new offerings. Data Source: HR records and staff rosters. **Milestone 10 Estimated Incentive Payment**: $399,648 **Milestone 11(I-11):** Increase primary care training. **Metric 11.1 (P-11.1):** Increase number of primary care course class size.	**Milestone 15 (P-2):** Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists **Metric 15.1 (P-2.2):** Hire additional precepting primary care faculty members/CME staff. Documentation: Increased number of additional training faculty/staff members. Baseline/goal: Add up to two (2) faculty members/CME staff to begin developing, offering new offerings. Data Source: HR records and staff rosters. **Milestone 15 Estimated Incentive Payment**: $340,696 **Milestone 16 (I-11):** Increase primary care training. **Metric 16.1 (P-11.1):** Increase number of primary care course class size.

[Unique Category 2 Project Identifier] **126686802.1.7**	*[Reference number of Project Option from RHP PP]* **1.2.1**	*[Reference Number of Project Component(s) from RHP PP -* ***N/A***	***UT Southwestern: UT Southwestern Office of CME Initiative:*** **Increasing CME Training of Primary Care Physicians**	
[RHP Performing Provider involved with this project - Name] ***Faculty Practice Plan at UT Southwestern Medical Center***				**126686802**
Related Category 3 Outcome Measure(s):	**126686802.3.29**	**IT-1.20**	**Educated Primary Care Workforce**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
precepting primary care faculty members/CME staff. Documentation: Increased number of additional training faculty/staff members. Baseline/goal: Current staff of 17. Add one (1) coordinator to begin developing, offering new offerings. Data Source: HR records and staff rosters. Rationale: More course offerings will require proportional increase in planning and coordination. **Milestone 2 Estimated Incentive Payment**: $449,435 **Milestone 3 (P-2):** Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists. **Metric 3.1 (P-2.3):** Develop alternative primary care training modalities. Baseline/goal: DY1 CME offerings	**Payment:** $393,580 **Milestone 7 (P-2):** Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists. **Metric 7.1 (P-2.3):** Develop alternative primary care training modalities. Baseline: DY2 CME offerings are the baseline. Goal: DY3 goal is to add up to 6 new CME offerings in various modalities. Data Source: CME course offering directories. Program curricula and dates offered. **Milestone 7 Estimated Incentive Payment**: $393,581 **Milestone 8 (I-11):** Increase primary care training. **Metric (I-11.6):** Improvement in trainee/enrollee knowledge assessment scores.		Baseline/goal: Increase overall attendance by 20% over DY2. Data Source: Program materials and enrollment records. **Milestone 11 Estimated Incentive Payment:** $399,648 **Milestone 12 (I-11):** Improvement in trainee satisfaction with specific elements of the training program. **Metric 12.1 (P-11.5):** Trainee satisfaction scores. Numerator: Sum of trainee/enrollee satisfaction scores. Denominator: Total number of trainees/enrollees. Data Source: Satisfaction assessment tool. Baseline/goal: DY3 scores is baseline. DY4 goal is 1% overall increase. Rationale: Regular assessment of trainee/enrollee satisfaction is critical to adapting programs to address needs. **Milestone 12 Estimated Incentive**	Baseline/goal: Increase overall attendance by 20% over DY2. Data Source: Program materials and enrollment records. **Milestone 16 Estimated Incentive Payment:** $340,696 **Milestone 17 (I-11):** Improvement in trainee satisfaction with specific elements of the training program. **Metric 17.1 (P-11.5):** Trainee satisfaction scores. Numerator: Sum of trainee/enrollee satisfaction scores. Denominator: Total number of trainees/enrollees. Data Source: Satisfaction assessment tool. Baseline/goal: DY4 scores is baseline. DY5 goal is 1% overall increase. Rationale: Regular assessment of trainee/enrollee satisfaction is critical to adapting programs to address needs.

[Unique Category 2 Project Identifier] **126686802.1.7**	*[Reference number of Project Option from RHP PP]* **1.2.1**	*[Reference Number of Project Component(s) from RHP PP -* ***N/A***	***UT Southwestern: UT Southwestern Office of CME Initiative:*** **Increasing CME Training of Primary Care Physicians**	
[RHP Performing Provider involved with this project - Name] ***Faculty Practice Plan at UT Southwestern Medical Center***				**126686802**
Related Category 3 Outcome Measure(s):	**126686802.3.29**	**IT-1.20**	**Educated Primary Care Workforce**	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
are the baseline. DY2 goal is to add up to 4 new CME offerings in various modalities. Data Source: CME course offering directories. Program curricula and dates offered. Rationale: Relevant content offered in different modalities increases availability. **Milestone 3 Estimated Incentive Payment**: $449,435 **Milestone 4 (P-6):** Develop/expand enrollment in programs that provide primary care training. **Metric 4.1 (P-6.1):** Provide training that will lead to commitment to implement new knowledge and skills for target populations. Baseline/goal: Baseline is previous enrollment in similar courses. Goal is to match or exceed prior year enrollment. Data Source: Course enrollment records, program materials. Rationale: The more enrollees, the more people will agree to		Numerator: Sum of differences in pre and post-test training assessment. Denominator: Number of enrollees in CME program. Baseline/goal: Baseline is Satisfaction scores from DY2 programs. Goal is 1% increase. Data Source: Knowledge assessment tool. **Milestone 8 Estimated Incentive Payment**: $393,581 **Milestone 9 (P-2):** Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists. **Metric 9.1 (P-2.2):** Hire additional precepting primary care faculty members/CME staff. Documentation: Increased number of additional training faculty/staff members. Baseline: DY2 staffing level	**Payment:** $399,649 **Milestone 13 (P-2):** Expand primary care training for primary care providers. **Metric 13.1 (P-2.3):** Develop alternative primary care training modalities. Baseline/goal: DY3 CME offerings is the baseline. DY4 goal is to add up to 6 new CME offerings in various modalities. Data Source: CME course offering directories. Program curricula and dates offered. **Milestone 13 Estimated Incentive Payment**: $399,649 **Milestone 14 (I-11):** Increase primary care training. **Metric 14.1 (I-11.6):** Improvement in trainee/enrollee knowledge assessment scores. Numerator: Sum of differences in pre and post-test training assessment. Denominator: Number of	**Milestone 17 Estimated Incentive Payment:** $340,696 **Milestone 18 (P-2):** Expand primary care training for primary care providers. **Metric 18.1 (P-2.3):** Develop alternative primary care training modalities. Baseline/goal: DY4 CME offerings is the baseline. DY5 goal is to add up to 6 new CME offerings in various modalities. Data Source: CME course offering directories. Program curricula and dates offered. **Milestone 18 Estimated Incentive Payment**: $340,697 **Milestone 19 (I-11):** Increase primary care training. **Metric 19.1 (I-11.6):** Improvement in trainee/enrollee knowledge assessment scores. Numerator: Sum of differences in pre and post-test training

[Unique Category 2 Project Identifier] **126686802.1.7**	*[Reference number of Project Option from RHP PP]* **1.2.1**	*[Reference Number of Project Component(s) from RHP PP -* ***N/A***	***UT Southwestern: UT Southwestern Office of CME Initiative:*** **Increasing CME Training of Primary Care Physicians**	
[RHP Performing Provider involved with this project - Name] ***Faculty Practice Plan at UT Southwestern Medical Center***				**126686802**
Related Category 3 Outcome Measure(s):	**126686802.3.29**	**IT-1.20**	**Educated Primary Care Workforce**	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
implement programs. **Milestone 4 Estimated Incentive Payment**: $449,436		Goal: Add two (2) faculty members/CME staff to begin developing, offering new offerings. Data Source: HR records and staff rosters. **Milestone 9 Estimated Incentive Payment**: $393,581	enrollees in CME program. Baseline/goal: Base line is DY3 Satisfaction scores. DY4 goal is 1% increase in overall score. Data Source: Knowledge assessment tool. **Milestone 14 Estimated Incentive Payment**: $399,649	assessment. Denominator: Number of enrollees in CME program. Baseline/goal: Base line is DY4 Satisfaction scores. DY5 goal is 1% increase in overall score. Data Source: Knowledge assessment tool. **Milestone 19 Estimated Incentive Payment**: $340,697
Year 2 Estimated Milestone Bundle Amount**: $1,797,741**		Year 3 Estimated Milestone Bundle Amount: **$1,967,903**	Year 4 Estimated Milestone Bundle Amount: **$1,998,243**	Year 5 Estimated Milestone Bundle Amount: **$1,703,482**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: **$7,467,369**				

Project Option: 1.2.1 - UT Southwestern Family Residency Program – Training Family Medicine Residents in Patient-Centered Medical Home and Chronic Disease Management

Unique Project ID: 126686802.1.8 (Pass 2)
Performing Provider Name/TPI: UT Southwestern Medical Center, TPI 126686802

Summary Information

Summary Description**:** This project will expand Family Medicine Residency training program classes to include training on the medical home, chronic care models, disease registry use, patient panel management, and other identified training needs and/or quality/performance improvement so when Residents graduate, they can join practices with those functions or they can initiate the practices in their new settings. The UTSW Family Medicine Residency Program residents gain most of their clinical experience during the training at the Parkland Memorial Hospital Family Medicine Clinic. That Clinic plans to implement the patient-centered medical home and other innovative concepts in the future. UTSW Residents will be pre-trained to help meet the goals of the Parkland Clinic.

Provider*:* The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds 452-beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, an average of 3% of UTSW patient visits was attributed to Medicaid patients across Parkland, Children's and UT Southwestern.

Intervention: To better prepare Family Medicine Residents to implement or participate in practice patterns and practice behaviors that will help continue healthcare delivery system reform, they will be provided education and training during their 3-year program that will prepare them to participate in the changes required or that are being implemented.

Need for Project: The RHP 9 Community Needs Assessment clearly identifies the shortage of primary care physicians and the need to implement programs such as patient-centered medical home in order to improve services, improve outcomes, and reduce costs of care to the people living in the Region.

Target Population: The UTSW Family Medicine Residency Program currently has 28 trainees across the three class graduation years. That number is projected to grow to 36 trainees. Information is critical to the future success of residents entering community practice. These physicians only treat Medicaid and low income patients during their Residency, seeing an estimated 20,000 patient visits annually.

Category 1 Expected Patient Benefits: The goal is to graduate Family Medicine physicians who are already trained and committed to applying the principles of patient centered medical home, chronic disease management and population management to Medicaid and low income populations.

Category 3 Outcomes:

OD-14: Outcomes for Workforce Projects

IT-14.1: Number of primary care practitioners per 1000 individuals in HPSAs or MUAs

Project Description:

This project will update Family Medicine Residency training program classes to include training on the medical home, chronic care models, disease registry use for population health management, patient panel management, and other identified training needs and/or quality/performance improvement so when Residents graduate, they can join practices with those functions or they can initiate the practices in their new settings. The UTSW Family Medicine Residency Program residents gain most of their clinical experience during the training at the Parkland Memorial Hospital Family Medicine Clinic. That Clinic plans to implement the patient-centered medical home and other innovative concepts in the future. UTSW Residents will be pre-trained to help meet the goals of the Parkland Clinic.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals:

The goal of the project is to educate all Family Medicine Residency faculty and residents in the principles and applications of initiatives such as patient centered medical home, chronic disease management, disease registry use for population health management, patient panel management, and other identified training needs and in principles of quality/performance improvement.

Region 9 priorities include improving primary care physician supply and capacity, improved care coordination, improved patient safety and quality. In order to achieve these goals, the practicing physician community needs to be increased. In addition, the practicing physicians must be made more knowledgeable and skills in implementing, participating in, and managing the various initiatives that will help Region 9 improve the delivery of services, improve outcomes and reduce the costs of care for all populations, but particularly Medicaid and low-income patients. By providing the requisite knowledge and skills to Family Medicine residents, they will be able to integrate into community practice setting more quickly. They also will be able to help implement and manage the desired initiatives more readily.

Challenges:

The demands on faculty to provide adequate, comprehensive education and training to residents are significant. There are many requirements that faculty leadership must meet in

developing the curriculum and assuring competency. The challenge will be the addition of more information to learn about different topics and skills to acquire that residents can then apply during the clinical training experiences and after graduation. The Family Medicine Residency faculty will develop a plan and implement teaching methods that will impart the desired knowledge and skills.

5-Year Expected Outcome for Providers and Patients:
The UTSW Family Medicine Residency Program currently has 28 trainees across the three class graduation years. That number is projected to grow to 36 trainees. Information is critical to the future success of residents entering community practice. These physicians only treat Medicaid and low income patients during their Residency, seeing an estimated 20,000 patient visits annually. By DY5, the Family Residency program will train up to 6 faculty and will graduate up to 36 family medicine physicians. The goal is to graduate Family Medicine physicians who are already trained and committed to applying the principles of patient centered medical home, chronic disease management and population management to Medicaid and low income populations and who will hopefully remain in the Dallas area and join practices that provide services to Medicaid and low-income patients.

Starting Point/Baseline:
The baseline is effectively zero because the Family Medicine Residency Program does not teach the specified course content.

Rationale:
Two of the five priorities identified in the RHP 9 Community Needs Assessment are Primary Care Capacity and Chronic Disease Management. This project addresses the needs of the region by training and motivating future family medicine physicians to understand, accept, and become committed to participating in initiatives that will benefit the target populations. Having applied their new knowledge and skills in a Medicaid clinic, it is hoped that the resident will be more likely to remain the RHP 9 and continue to serve Medicaid and low-income patients.

Texas has a growing shortage of primary care doctors and nurses due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in Texas is a critical problem that we have the opportunity to begin addressing under this waiver. It is difficult to recruit and hire primary care physicians. The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. Expanding the primary care workforce will increase access and capacity and help create an organized structure of primary care providers, clinicians, and staff. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. The extended primary care workforce will also be trained to operate in patient-centered medical homes. A greater focus on primary care will be crucial to the success of an integrated health care system. Furthermore, in order to effectively operate in a medical home model, there is a need for residency and training

programs to expand the capabilities of primary care providers and other staff to effectively provide team-based care and manage population health. Therefore, the need to expand the responsibilities of primary care workforce members will be even more important. In summary, the goal for this project is to train more workforce members to serve as primary care providers, clinicians, and staff to help address the substantial primary care workforce shortage and to update training programs to include more organized care delivery models. This project may apply to primary care physicians (including residents in training), nurse practitioners, physician assistants, and other clinicians/staff (e.g., health coaches, community health workers/promotoras) in the following service areas: family medicine, internal medicine, obstetrics and gynecology, geriatrics, and pediatrics.

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively. (Comparable ratios for US Total are 219.5 and 90.5, respectively.) From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Primary care physician workforce grew only 25% in the same period. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762 in line with the national call by the Association of American Medical Colleges to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates. Coincidentally, there were 1,445 allopathic entry-level GME positions offered in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions by 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.

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

This project is a new initiative within the Family Medicine Residency Program. However, it complements other initiatives by the UTSW Faculty Practice Plan and the UTSW Clinical Affiliates Program. Taken together, all of these efforts will strongly support the goals of RHP 9.

This project addresses the needs of the region by training and motivating future family medicine physicians to understand, accept, and become committed to participating in initiatives that will benefit the target populations. Having applied their new knowledge and skills in a Medicaid clinic, it is hoped that the resident will be more likely to remain the RHP 9 and continue to serve Medicaid and low-income patients.

Community Needs Addressed:

The Community Needs Assessment specifically addressed by the project include:

- CN.3 Healthcare Capacity
- CN.4 Primary Care and Pediatrics
- CN.8 Chronic Disease
- CN.11 Patient Safety and Quality

CN.12 Emergency Department Usage and Readmissions

Projects being proposed across RHP 9 include developing or expanding use of the Patient-Centered Medical Home and developing or expanding use of various Chronic Disease Management approaches. These and other projects will require additional knowledge and skills, along with changes to how physician practices are managed. Evidenced-based education and the resultant behavior changes are a significant undertaking. At the same time, if we don't educate and train existing primary care workforces, our ability to implement innovative PCMH and Chronic Disease Management programs will be severely limited. UT Southwestern has a well-established Office of CME that understands how to educate providers so that they can better absorb and adopt new processes, protocols, and performance improving techniques. Targeted CME programs will improve the value of the current primary care workforce while we are also working to expand that workforce.

The variety of methods for providing CME allow physicians to schedule their learning opportunities when it is most convenient and effective for their practice schedules. Many methods also offer cost-effective ways to reach larger populations of providers regardless of where they are located.

Related Category 3 Outcome Measure(s):

OD-14: Outcomes for Workforce Projects

IT-14.1: Number of primary care practitioners per 1000 individuals in HPSAs or MUAs

This measure reflects the need to increase the number of primary care practitioners caring for the target populations, especially if they have the skills needed in an ear of healthcare reform and transformation.

Relationship to other Projects:

This project is directly related to the following projects because this project provides the education and training that will assist newly graduated primary care providers to understand and support implementation of them:

- 126686802.1.1 Establish a New Primary Care Clinic
- 126686802.1.2 Expand Primary Care Capacity in the UTSCAP Network
- 126686802.1.7 Expand CME Courses to Train Primary Care Providers
- 126686802.1.10 Implement a Population Management Infrastructure
- 126686802.2.6 Conduct Medication Management

Relationship to Other Performing Providers' Projects in the RHP: No other project in RHP 9 proposes to provide education and training to Family Medicine residents.

Plan for Learning Collaborative: The Anchor plans to develop and facilitate Learning Collaboratives in the Region with DFW Hospital Council. UT Southwestern will participate in the Collaborative(s) as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation:

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

This project's score for this criteria: 4.00

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

This project's score for this criteria: 4.00

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 3.00

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 4.35

6. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 5.00

Total Valuation Score for this project: **3.80**

[Unique Category 2 Project Identifier] **126686802.1.8**	*[Reference number of Project Option from RHP PP]* **1.2.1**	*[Reference Number of Project Component(s) from RHP PP -* ***NA***	**UT Southwestern Family Residency Program – Training Family Medicine Residents in Patient-Centered Medical Home and Chronic Disease Management**	
UT Southwestern Medical Center Faculty Practice Plan				**126686802**
Related Category 3 Outcome Measure(s):	**126686802.3.30**	**IT-14.1**	**Number of primary care practitioners per 1000 individuals in HPSAs or MUAs**	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 (P.1): Conduct a gap analysis to determine residency program training needs. Metric (P-1.1): Assessment of faculty staffing and training content needs. Data Source: Standards for staffing and training; assessment results. **Milestone 1 Estimated Incentive Payment**: $226,613 **Milestone 2 (P-3):** Expand positive primary care exposure for residents. Metric (P-3.1): Documented plan for mentoring program with Family Medicine faculty and new residents. Data Source: Mentoring program curriculum. **Milestone 2 Estimated Incentive Payment:** $226,614 **Milestone 3 (P-3):** Expand positive primary care exposure for residents. Metric (P-3.2): Documented plan to train residents in the medical home, chronic care model or disease registry use. Data Source: Curriculum plan. **Milestone 3 Estimated Incentive**	**Milestone 6 (P-2):** Expand Family Residency training for primary care providers Metric (P-2.1): Document agreements to expand the Family Medicine Residency curriculum and faculty Data Source: Process steps and Approval documents **Milestone 6 Estimated Incentive Payment**: $262,675 **Milestone 7 [P-2]:** Expand Family Residency training for primary care providers Metric (P-2.2): Hire additional precepting faculty. Baseline/goal: Hire at least 1 additional faculty member over DY2 roster. Data Source: HR documents **Milestone 2 Estimated Incentive Payment:** $262,675 **Milestone 8 (P-3):** Expand positive primary care exposure for residents. Metric (P-3.1): Implement plan for mentoring program with Family		**Milestone 11 [P-2]:** Expand Family Residency training for primary care providers Metric (P-2.2): Hire additional precepting faculty. Baseline/goal: Hire at least 1 additional faculty member over DY2 roster. Data Source: HR documents **Milestone 11 Estimated Incentive Payment:** $265,390 **Milestone 12 (P-3):** Expand positive primary care exposure for residents. Metric (P-3.1): Implement plan for mentoring program with Family Medicine faculty and new residents. Baseline: Baseline of zero since it is first year of program. Goal: Goal of at least 6 residents participating. Data Source: Mentoring program curriculum and list of participants. **Milestone 12 Estimated Incentive Payment:** $265,390 **Milestone 13 (P-3):** Expand positive primary care exposure for residents.	**Milestone 16 [P-3]:** Expand positive primary care exposure for residents. Metric (P-3.1): Expand mentoring program with Family Medicine faculty and new residents. Baseline/goal: Baseline is DY4. Goal of at least 9 residents participating. Data Source: Mentoring program curriculum and list of participants. **Milestone 16 Estimated Incentive Payment:** $284,225 **Milestone 17 (P-3):** Expand positive primary care exposure for residents. Metric (P-3.2): Expand training of residents in the medical home, chronic care model or disease registry use. Baseline/goal: Baseline is number of residents participating in DY4. Goal of at least 10 residents participating. Data Source: Curriculum and list of participants. **Milestone 17 Estimated Incentive Payment:** $284,225 **Milestone 18 (I-11):** Increase primary care training.

[Unique Category 2 Project Identifier] **126686802.1.8**	*[Reference number of Project Option from RHP PP]* **1.2.1**	*[Reference Number of Project Component(s) from RHP PP -* ***NA***	**UT Southwestern Family Residency Program – Training Family Medicine Residents in Patient-Centered Medical Home and Chronic Disease Management**	
UT Southwestern Medical Center Faculty Practice Plan				**126686802**
Related Category 3 Outcome Measure(s):	**126686802.3.30**	**IT-14.1**	**Number of primary care practitioners per 1000 individuals in HPSAs or MUAs**	
Year 2 **(10/1/2012 – 9/30/2013)**	**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: $226,614 **Milestone 4 (P-3):** Expand positive primary care exposure for residents. Metric (P-3.3): Develop plan to include residents in quality improvement projects. Data Source: Curriculum and list of potential quality improvement projects. **Milestone 4 Estimated Incentive Payment**: $226,614 **Milestone 5 [P-10]:** Obtain approval to expand curriculum and, if needed, to increase faculty to accommodate expanded curriculum. Metric (P-3.1): Submit proposal and budget to Dean's office, and elsewhere as appropriate. Data Source: Evidence-based justification for expanded curriculum and additional faculty. **Milestone 5 Estimated Incentive Payment**: $226,614	Medicine faculty and new residents. Baseline/goal: Baseline of zero since it is first year of program. Goal of at least 3 residents participating. Data Source: Mentoring program curriculum and list of participants. **Milestone 8 Estimated Incentive Payment:** $262,675 **Milestone 9 (P-3):** Expand positive primary care exposure for residents. Metric (P-3.2): Implement plan to train residents in the medical home, chronic care model or disease registry use. Baseline/goal: Baseline of zero since it is first year of program. Goal of at least 6 residents participating. Data Source: Curriculum and list of participants. **Milestone 9 Estimated Incentive Payment:** $262,675 **Milestone 10 (P-9):** Develop and disseminate clinical teaching tools for primary care or interdisciplinary clinics or site. Metric (P-9.1): Clinical teaching tools.		Metric (P-3.2): Implement plan to train residents in the medical home, chronic care model or disease registry use. Baseline/goal: Baseline of zero since it is first year of program. Goal of at least 8 residents participating. Data Source: Curriculum and list of participants. **Milestone 13 Estimated Incentive Payment:** $265,390 **Milestone 14 (I-11):** Increase primary care training. Metric (I-11.5): Improvement in resident satisfaction with specific elements of the training program. Baseline/goal: Baseline of zero since it is first year of measuring satisfaction. Goal of at least 6 residents participating. Numerator: Sum of trainee satisfaction scores. Denominator: Total number of residents surveyed. Data Source: Satisfaction assessment tool. **Milestone 14 Estimated Incentive**	Metric (I-11.5): Improvement in resident satisfaction with specific elements of the training program. Baseline/goal: Baseline is DY4 results. Goal is 2% improvement I overall score. Numerator: Sum of trainee satisfaction scores. Denominator: Total number of residents surveyed. Data Source: Satisfaction assessment tool. **Milestone 18 Estimated Incentive Payment:** $284,225 **Milestone 19 (I-11):** Increase primary care training. Metric (I-11.6): Improvement in resident knowledge assessment scores. Baseline/goal: DY4 results are the baseline. Goal is 3% improvement over DY4. Numerator: Sum differences in pre and post-test score scores. Denominator: Total number of residents surveyed. Data Source: Satisfaction assessment

[Unique Category 2 Project Identifier] **126686802.1.8**	*[Reference number of Project Option from RHP PP]* **1.2.1**	*[Reference Number of Project Component(s) from RHP PP -* ***NA***	**UT Southwestern Family Residency Program – Training Family Medicine Residents in Patient-Centered Medical Home and Chronic Disease Management**	
UT Southwestern Medical Center Faculty Practice Plan				**126686802**
Related Category 3 Outcome Measure(s):	**126686802.3.30**	**IT-14.1**	**Number of primary care practitioners per 1000 individuals in HPSAs or MUAs**	
Year 2 **(10/1/2012 – 9/30/2013)**	**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: Faculty or other institutions that can act as consultants. **Milestone 10 Estimated Incentive Payment:** $262,675		**Payment:** $265,390 **Milestone 15 (I-11):** Increase primary care training. Metric (I-11.6): Improvement in resident knowledge assessment scores. Numerator: Sum differences in pre and post-test score scores. Denominator: Total number of residents surveyed. Data Source: Satisfaction assessment tool. **Milestone 15 Estimated Incentive Payment:** $265,390	tool. **Milestone 19 Estimated Incentive Payment:** $284,226
Year 2 Estimated Milestone Bundle Amount: $1,133,069	**Year 3 Estimated Milestone Bundle Amount:** $1,313,375		**Year 4 Estimated Milestone Bundle Amount:** $1,326,950	**Year 5 Estimated Milestone Bundle Amount:** $1,136,901
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* **$4,910,295**				

Project Option: 1.2.2 – Increase the number of Primary Care Providers
Title of Project: Increasing Access to Primary Care: The Expansion and Redesign of the UT Southwestern Physician Assistant Program

RHP Project Identification Number: 126686802.1.9 (Pass 2)
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW") / TPI 126686802

Summary Information:
Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds 452-beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, an average of 24% of UTSW patient visits was attributed to Medicaid patients across Parkland, Children's and UT Southwestern.

Intervention(s): UTSW will increase the class enrollment size and the redesign the curriculum of the UT Southwestern Physician Assistant ("PA") program (including reducing the time to graduation) in our effort to address the shortage of primary care providers and foster an interest in primary care as a specialty for PA trainees.

Need for the Project: In order to address the demand for primary care services in our Region, UT Southwestern proposes a comprehensive project to increase the production of PA's in the Region who are life-long learners, with substantial clinical knowledge, coupled with culturally sensitive abilities that are able to meet the needs of a demographically changing patient population.

Target Population: Students and graduates of the UTSW Physician Assistant program are the primary target population. By enhancing their education and training with skills appropriate to healthcare reform and treating Medicaid and low income populations, it is expected that they will more likely seek where the ultimate target population is served.

Category 1 or 2 Expected Patient Benefits: Increasing the annual class size from 36 to 60 students, and streamlining the curriculum of the PA Program, will result in almost doubling the available providers to the Region. New efforts will be made to increase the number of PA graduates that work in primary care and with underserved populations. The new graduates will have enhanced knowledge and skills in topics essential to healthcare reform and transformation success. The value of each additional primary care practitioners is an average of 1500-2000 unique patients and as many 5,000 patient visits per year per new provider.

Category 3 Outcome Measures:

OD-14 – Outcomes for Workforce Projects

IT-14.2 – Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs

Project Description:

UT Southwestern proposes to increase the class enrollment size and the redesign the curriculum of the UT Southwestern Physician Assistant ("PA") program.

This expansion of the program plays an important role in our Region's effort to increase access and capacity in primary care. To accomplish the expansion of the PA Program, UT Southwestern proposes to 1) reduce the time-to-degree from the current 30 months to 24 months, thus enabling a more nimble response to health workforce needs; 2) incrementally increase annual student enrollment from the baseline of 36 to a goal of 60 students per enrollment year (60% increase); 3) add additional on-campus and external/off-campus resources for clinical and teaching experiences, and 4) increase the number of PA faculty available for the curriculum's required small group teaching in the program's first year.

However, expansion alone is not enough in our efforts to produce additional primary care providers in our Region and in Texas. Thus, UT Southwestern also proposes to foster an interest in primary care as a specialty for PA trainees and build on a team-based approach to healthcare that recognizes and appreciates the role of PA's at UT Southwestern.

Collaboration

This project is being proposed through a collaboration agreement. The specific collaboration arrangement for this project is set forth below.

Collaborators	DY2	DY3	DY4	DY5	Total
Parkland Memorial Hospital	513,723	702,925	860,336	1,021,564	3,098,548
Project / Collaboration	**DY2**	**DY3**	**DY4**	**DY5**	**Total**
Category 2 Project Value	1,133,069	1,313,375	1,326,950	1,136,901	4,910,295
Related Category 3 Projects Value	59,801	144,671	245,751	387,683	837,906
Total Project Value	**1,192,876**	**1,458,046**	**1,572,701**	**1,524,584**	**5,748,201**

The collaboration involves the transfer of Pass 2 allocated dollars from Parkland Memorial Hospital (public entity) to the performing provider (public entity). The combined project value for this project exceeds the funding provided by the collaborating entity.

The collaborating parties have joined together in this collaboration with the belief that the goals of this project are valuable and will contribute to regional transformation. This project will intersect with the Parkland Project 127295703.2.11 to enhance/expand the medical home model for the family medicine clinic associated with this training initiative.

Goals and Relationship to Regional Goals:

The primary goal of this project is to increase the primary care capacity within our Region and Texas. Specifically, the project goals are as follows:

- Streamline the curriculum by concentrating content from 30 to 24 months;
- Increase the number of PA trainees enrolled at UT Southwestern;
- Foster and develop an interest in primary care by UT Southwestern PA trainees; and
- Develop, reinforce and build on a culture of health care delivery through a team approach that utilizes PA's at UT Southwestern.

This project also meets the Regional goal of increasing the primary care capacity and reducing the shortage of primary care providers in our Region.

Challenges:

Our PA Program faces the following challenges in training PA's for a career in primary care. First, the current clinical environment and culture at UT Southwestern does not maximize the use of PA's in the delivery of primary care services. Despite a forty-year campus presence, the acceptance and ideal utilization of PA's as non-physician clinicians has not been consistent over time; thus, there is less opportunity for clinical utilization role-modeling and professional socialization for the trainees. Second, PA's have opportunities to practice in varying specialties that generally provide greater salaries than primary care practice. For example, the 2010 census by the American Academy of Physician Assistants, thirty-one (31) percent of PA's primary specialty is in primary care and the median annual compensation is the lowest in this specialty. However, with renewed support and a desire to build on a culture of providing health care through a team-based approach at UT Southwestern and the support of our Regional Partners' for clinical rotations in primary care settings, the project will be successful.

5-Year Expected Outcome for Provider and Patients:

The 5-year expected outcome for patients in our Region is an increase in the number of students enrolled in its PA Program by 60%, from a baseline of 36 to a first year enrollment of 60 students by DY5. This increase in class size will result in the production of an additional 70 PAs available to practice in our Region by DY5. Increasing the annual class size and streamlining the curriculum of the PA Program, resulting in an increase in available primary care providers to the Region, will serve the patients throughout our Region in need of primary care services and support the mission of UT Southwestern to educate future health care providers. In addition, UT Southwestern expects to increase the PA program's focus on innovative primary care models in its curriculum through the exposure of trainees to the patient centered medical home model and participation of trainees in quality improvement projects, all while building on a team-based approach to healthcare at UT Southwestern. The value of each additional primary care practitioners is an average of 1500-2000 unique patients and as many 5,000 patient visits per year per new provider.

Starting Point/Baseline:

As of December 1, 2011, one thousand one hundred forty-five (1,145) applicants applied to the Program for filling the class size of thirty-six (36) students. The 2011 class includes 6 educationally disadvantaged, 1 economically disadvantaged, 3 under-represented minority, 2 other minority students. The faculty consists of 6.5 full time equivalent (FTE) faculty members. The program is currently a 30-month full-time master's degree program, which is a rapid approach to addressing the primary care provider shortage. The curriculum is divided into a 15-month didactic phase followed by a fifteen-month clinical phase. With a current instructional faculty complement of 6.5 FTE and an annualized enrollment of 96 students, our student-to-faculty ratio is 14.8:1, compared to the U.S. mean student/faculty ratio is 14.3:1.

The UT Southwestern PA Program commenced in 1972 with six students, and by 2011 the Program had 1,000 graduates, over 70% of who are licensed to practice in Texas. This PA Program is one of the most academically successful in the U.S., having achieved a five-year first-time pass rate on the Physician Assistant National Certifying Examination of 100%, one of only five (out of 164) programs in the country able to make this claim. It is currently ranked 8th nationally by U.S. News & World Report. The program has earned lengthy periods of continuing accreditation from the Accreditation Review Commission on Education for the Physician Assistant, Inc., and is now on a second consecutive cycle of seven years accreditation, the maximum granted length.

Rationale:

In order to address the demand for primary care services in our Region, UT Southwestern proposes a comprehensive project to increase the production of PA's in the Region who are life-long learners, with substantial clinical knowledge, coupled with culturally sensitive abilities that are able to meet the needs of a demographically changing patient population. Although not every PA trained at UT Southwestern stays within the Region, a majority stay within North Texas. The demand for primary care services in our Region is a current demand, and the time required to produce one licensed primary care physician is approximately seven to eight years. The time required to produce one licensed primary care physician assistant is approximately three years.

In the face of an immediate challenge by the current and expected future shortage of primary care physicians, the expansion of Medicaid, and the important role PA's play in the delivery of primary care services, expanding the UT Southwestern PA program is a sound approach to producing more primary care providers in a relatively short time period. In addition to increasing class size of the PA Program, UT Southwestern is also aware of the need to develop and maintain an interest in primary care service for its trainees.

Thus, UT Southwestern will not only increase the enrollment size of the PA Program, but it will also foster an interest in primary care through the following selected milestones:

- Expand positive primary care exposure for PA trainees through an expansion of primary care clinical rotations;

- Train PA trainees in the patient centered medical home model; and

- Include PA trainees/rotations in quality improvement projects.

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

The UT Southwestern PA Program is currently a 30-month full-time master's degree program with an annual enrollment maximum of thirty-six (36) students. The project will streamline the current curriculum by reducing the program to a 24-month full-time master's degree program and increase the annual enrollment size by 60%. With the shortage of physicians selecting primary care as their practice area, the expansion of PA's is critical to addressing the gap of primary care providers in the Region and in Texas. However, PA's must also be attracted to primary care practice. UT Southwestern's project will address these issues by not only expanding the number of PA's available to our Region but through a PA trainee curriculum designed to foster an interest in primary care practice.

Community Needs Addressed:

The specific and unique community need identification numbers that this project addresses include the following:

- CN.2 Regional Healthcare Infrastructure and Patient Migration Patterns
- CN.3 Healthcare Capacity
- CN.4 Primary Care and Pediatrics

In addition, the community need for primary care providers in RHP9 is well-documented. According to the U.S. Government Accountability Office (http://www.gao.gov/new.items /d08472t.pdf), the national supply of primary care providers per 100,000 population is 90 physicians, 28 nurse practitioners, and 8 physician assistants, for a total of 126 providers per 100K population. Although Kaufman County has no Federally-designated Health Professional Shortage Areas, the primary care provider to 100,000 population ratio is the lowest among the three-county region, at 34.8/100K (http://county-health.findthedata.org/l/2650/Kaufman). Denton and Dallas Counties also suffer from a shortage of primary care providers, with Denton County reporting 51.8/100K and Dallas County with 83.9/100K population (http://www.texastribune.org/library/data/primary-care-workforce-shortages/). Furthermore, Dallas and Denton Counties have a number of Health Professional Shortage Areas, as described in the RHP 9 Community Needs Assessment (CNA.1).

Related Category 3 Outcome Measure(s):

OD-14 – Outcomes for Workforce Projects

IT-14.2 – Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs

This Outcome Measure is selected to address the severe shortage of healthcare professionals in the Region 9 service area. By expanding the PA program and providing education and

experience treating the target population, it is expected that more practitioners will end up serving their needs after graduation.

Relationship to other Projects:
This project's focus on expanding primary care providers and emphasis on redesigning the PA program's curriculum to foster an interest in primary care ties to the following Category 1 and 2 projects:

- *126686802.1.2—Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics*
- *126686802.2.1—Expanding the Medical Home Model in the UTSCAP Primary Care Network*
- *126686802.1.4—Implement UT Southwestern Population Management Infrastructure Development*
- *126686802.1.1.2—Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics*
- *126686802.2.2 –Applying process improvement methodology to improve quality and efficiency by training in the methodology of quality improvement*

Relationship to Other Performing Providers' Projects in the RHP:
No other providers in the RHP are expanding primary care trainees that will be licensed practicing providers.

Plan for Learning Collaborative: No other projects involve educating physician assistants. Therefore, there will be no opportunity for a Learning Collaborative.

Project Valuation:
A number of studies have been done to asses productivity of PAs compared to physician productivity. Not only are the comparisons favorable, there is some evidence that PAs see more patients per year than physicians do, and the utilization of PAs resulted in higher clinical productivity rates overall. (Crandall 1984; Hooker 1986; Hooker 1993; Scheffler 1996). Community benefit has also been documented by incorporating PAs into the provider mix. According to a Stanford University study by Hauser, "PAs appear not only to be cost effective, have the ability to provide comparable quality of primary medicine, and receive equal patient satisfaction, but it also appears they can significantly ameliorate the obstacle of access to care in underserved areas."

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of

total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

This project's score for this criterion: 9.00

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

This project's score for this criterion: 5.20

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criterion: 9.00

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criterion: 5.00

6. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criterion: 9.00

Total Valuation Score for this project: 7.00

[Unique Category 1 Project Identifier] 126686802.1.9	*Project Option 1.2.2*		*Increasing Access to Primary Care: The Expansion and Redesign of the UT Southwestern Physician Assistant Program*	
UT Southwestern Medical Center				*TPI 126686802*
Related Category 3 Outcome Measure(s):	**26686802.3.31**	**IT-14.2**	**Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs**	
Year 2 (10/1/2012 – 9/30/2013)	**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 in order to do appropriate planning for the implementation of a major PA program and process redesign. Metric 1.1 [*P-X.1*]: Baseline/Goal: Documentation of the plan to: Redesign PA curriculum to include medical home model and quality improvement projects, Streamline the curriculum by concentrating content from 30 to 24 months, Increase PA faculty, Increase PA enrollees, and Document barriers to these objectives and create a working plan to address such barriers. Data Source: The Planning Report. **Milestone 1 Estimated Incentive Payment: $1,142,930** **Milestone 2** [P-2]: Expand primary	**Milestone 3** [P-2]: Expand primary care training for primary care providers Metric 4.1 [P-2.2]: Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline: 6.5 full time equivalent (FTE) faculty members. Goal: 15% increase in the number of training faculty members. Data Source: HR documents and faculty lists. **Milestone 3 Estimated Incentive Payment: $805,928** **Milestone 4** [P-3]: Expand positive primary care exposure for PA trainees Metric 5.1 [P-3.3]: Include PA trainees/rotations in quality improvement projects. Baseline/Goal: Documentation of program Data Source: Curriculum and/or quality improvement project documentation/data **Milestone 4 Estimated Incentive Payment: $805,928**		**Milestone 6** [P-2]: Expand primary care training for primary care providers Metric 7.1 [P-2.2]: Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (baseline for DY3). Baseline/Goal: 13% increase in the number of additional training faculty members. Data Source: HR documents, faculty lists or other documentation. **Milestone 6 Estimated Incentive Payment: $814,258** **Milestone 7** [P-3]: Expand positive primary care exposure for PA trainees Metric 8.1 [P-3.3]: Train PA trainees in the patient centered medical home model, chronic care model and/or disease registry use, have primary care trainees participate in medical homes by managing panels. Baseline/Goal: Documentation of program Data Source: Curriculum and rotation hours. **Milestone 7 Estimated Incentive**	**Milestone 9**[I-11]: Increase primary care training and/or rotations. Metric 10.1 [I-11.1]: Increase the number of primary care trainees, as measures by percent change in class size over baseline. *Note: demonstrate improvement over prior reporting period.* Baseline: 50 number of new PA trainees Goal: 17% increase (from 50 to 60) in class size Data Source: Documented enrollment by class by year by primary care training program. **Milestone 9 Estimated Incentive Payment: $1,046,457** **Milestone 10** [P-2]: Expand primary care training for primary care providers Metric 11.1 [P-2.2]: Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (baseline for DY4). Baseline/Goal: 24% increase in the number of additional training faculty members.

[Unique Category 1 Project Identifier] 126686802.1.9	*Project Option 1.2.2*		*Increasing Access to Primary Care: The Expansion and Redesign of the UT Southwestern Physician Assistant Program*	
UT Southwestern Medical Center				*TPI 126686802*
Related Category 3 Outcome Measure(s):	**26686802.3.31**	**IT-14.2**	**Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
care training for primary care providers (physician assistants). Metric 2.1 [P-2.1]: Expand the physician assistant training program. Baseline/Goal: Documentation of applications and agreement to expand the training program. Data Source: Training program documentation. **Milestone 2 Estimated Incentive Payment: $1,142,930**	**Milestone 5** [I-11]: Increase primary care training and/or rotations. Metric 6.1 [I-11.1]: Increase the number of primary care trainees, as measures by percent change in class size over baseline. Baseline: 36 number of new PA trainees Goal: 25% increase (from 36 to 45) in class size Data Source: Documented enrollment by class by year by primary care training program. **Milestone 5 Estimated Incentive Payment: $805,928**		**Payment: $814,258** **Milestone 8** [I-11]: Increase primary care training and/or rotations. Metric 9.1 [I-11.1]: Increase the number of primary care trainees, as measures by percent change in class size over baseline. Baseline: 45 number of new PA trainees Goal: 10% increase (from 45 to 50) in class size Data Source: Documented enrollment by class by year by primary care training program. **Milestone 8 Estimated Incentive Payment: $814,258**	Data Source: HR documents, faculty lists or other documentation. **Milestone 10Estimated Incentive Payment: $1,046,457**
Year 2 Estimated Milestone Bundle Amount: $2,285,860	**Year 3 Estimated Milestone Bundle Amount: $2,417,784**		**Year 4 Estimated Milestone Bundle Amount: $2,442,774**	**Year 5 Estimated Milestone Bundle Amount: $2,092,914**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $9,239,332				

Project Option 1.2.2: Training of Community Health Workers (CHWs)

Unique Project ID: 126686802.1.10
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center ("UTSW") Faculty Practice Plan/ TPI 126686802

Summary Information
Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds 452-beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus.

Intervention(s): This project will develop a program designed to increase the number of certified CHWs in the region and respond to specific continuing education needs as identified by providers and CHWs.

Need for the project: Access to primary care, high emergency department utilization, high blood pressure, and a high rate of hospital readmissions are serious issues in RHP 9. To address some of these cost drivers, the Region needs more primary care resources to deploy in unique ways and in low cost settings. Therefore, we are proposing increasing the availability and utilization of certified CHWs trained in organized care delivery models.

Target population: The target population is all patients seen by UT Southwestern. Our hospital attributes days serving patients at 11% for Medicaid (i.e. based on weighted patient days). However, Community Health Workers will see anyone in the community regardless of where they receive their care. We expect Training Community Health Workers will improve access for all RHP 9 populations.

Category 1 or 2 expected patient benefits: This project is expected to benefit patients by providing additional access to primary care resources. We believe these resources and the additional care access will result in patients being more engaged in their own care as well as being able to avoid unnecessary readmissions, ED visits, and doctor visits. Finally we expect to positively impact blood pressure in the targeted population.

UTSW physicians provided care to Charity and Medicaid patients during 16,175 visits which were specifically at UT Southwestern outpatient practices. In 2012, UT Southwestern Hospital – St. Paul had a total of 34,293 ER cases, of those cases 40% where provided to Medicaid/Charity/low income patients. Patients admitted through the ER had a substantially higher readmit rate than non-ER patients. In addition, the percent of low income patients actually needing hospitalization was disproportionately low to all other patients who sought care in the ER. To benefit these and all RHP 9 patients, UTSW intends to expand access to primary care resources by training Community Health Workers. Our expectation is that this program will have a substantial impact on many patients in RHP 9. By adding approximately 126 primary care physicians, UTSW expects that by DY5 approximately 277,000 patients,

including 44,000 Medicaid/low income patients, could benefit from this program. We expect that by making available these additional primary care resources to the community, access will be expanded and costs can be reduced by avoiding care provided in high cost settings.

Category 3 outcomes:

IT-1.7 Controlling high blood pressure

Project Description:

This project will facilitate the expansion of primary care resources of the health care system in RHP 9. UT Southwestern will develop a program designed to increase the number of certified CHWs in the region and respond to specific continuing education needs as identified by providers and CHWs. Providers and clinic staff will be trained in how to integrate CHWs as members of the health care team.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goal and Relationship to Regional Goals:

Increase availability and utilization of certified CHWs trained in organized care delivery models, with an emphasis on team-based practice, quality and cost control, that will serve as members of healthcare delivery teams.

CHWs will be invaluable in helping the region achieve its goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system".

This project also meets the following regional goals:

Access to primary care, high emergency department utilization and a high rate of hospital readmissions are serious issues in our RHP 9. CHWs can use their unique understanding of the experiences, language and/or culture of the populations they serve to promote health of our community and reduce the burden of illness.

Challenges:

Need: 1) Lack of access to culturally appropriate care. 2) Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs.

Implementation: 1) Willingness of other providers/clinicians to incorporate CHWs in their care team. 2) Retention of trained CHWs. CHWs have been proven to be effective in serving as linkages between patients and the health system, helping patients to navigate the daunting challenges posed by the fragmented nature of health care delivery in the US. Most CHWs come

from the local population, are in touch with the community, and are better able to attend to the needs of patients by helping the system to deliver culturally sensitive care and by facilitating their access to health education and support, thereby providing an important and cost effective service to health care teams and to patients. Providers/clinicians will be training in the value that CHWs bring to the health care team and in how to incorporate them into the practice. The inclusion of CHWs into care teams in their community and competitive compensation will aid in the retention of trained CHWs.

5-Year Expected Outcome for Provider and Patients:

UTSW physicians provided care to Charity and Medicaid patients during 16,175 visits which were specifically at UT Southwestern outpatient practices. In 2012, UT Southwestern Hospital – St. Paul had a total of 34,293 ER cases, of those cases 40% where provided to Medicaid/Charity/low income patients. Patients admitted through the ER had a substantially higher readmit rate than non-ER patients. In addition, the percent of low income patients actually needing hospitalization was disproportionately low to all other patients who sought care in the ER. To benefit these and all RHP 9 patients, UTSW intends to expand access to primary care resources by training Community Health Workers. Our expectation is that this program will have a substantial impact on many patients in RHP 9. By adding approximately 126 primary care physicians, UTSW expects that by DY5 approximately 277,000 patients, including 44,000 Medicaid/low income patients, could benefit from this program. We expect that by making available these additional primary care resources to the community, access will be expanded and costs can be reduced by avoiding care provided in high cost settings. Several CHWs will have been trained for practice in the region, and more practices will have CHWs employed in team-based management models. Since CHWs are able to provide patients with culturally appropriate assistance, we would expect better health outcomes. For this project, the focus is on reducing rates of high blood pressure in patients of the target population.

Starting Point/Baseline:

UTSW does not currently engage CHW's; thus, this is a completely new initiative for UTSW. The baseline is zero. UTSW will be initiating this program in DY2.

Rationale:

CHWs are members of a team of public health professionals who use their unique understanding of the experiences, language and/or culture of the populations they serve to promote health. CHWs have proven to be an important link between healthcare providers, researchers and disadvantaged communities.

As leaders, CHWs bridge the gap between communities and the health care system – they act as liaisons between health care providers and patients. In the United States, CHWs have been a part of the health care delivery system since the 1960s. Their role has evolved over time and varies according to their work setting, which ranges from outreach workers in the community to clinic staff. CHWs have a broad skill set, including communication, leadership, advocacy, and both general and disease or condition-specific health knowledge. Duties performed by CHWs

range from counseling and health education to basic clinical tasks (HRSA, 2007). Regardless of their work environment, CHWs are trusted members of the community in which they work and typically reflect the demographic characteristics of the area. Their knowledge of the community allows them to effectively relay culturally competent information to community members, connect them to local health and social services, and advocate on their behalf. Nationally and internationally, CHWs are viewed as part of the solution for achieving improved health status in rural and disenfranchised communities.

For many years CHWs have provided an array of health care services in different settings. Recently their role has been elevated, nationally and internationally, as opportunities for integrating CHWs into the health care delivery system are discussed. In 2009, the US Department of Labor recommended the creation of a Standard Occupational Classification for CHWs. This act opened the door for additional integration into the US health system. The 2010 Patient Protection and Affordable Care Act (health reform law) identified community health workers as having major roles in achieving the goals of health care reform and a means of addressing health inequities. At the International level, the United Nations Millennium Development Goals (MDGs) acknowledge the importance of human capital. In an effort to progress toward meeting health-related MDGs, the World Health Organization recommends CHWs as a part of the health service workforce (Achieving the health-related MDGs. It takes a workforce! 2010).

This project aims to demonstrate improved health outcomes, return-on-investment, and increased patient satisfaction when CHWs are integrated into the health care team affiliated with UT Southwestern.

- Increased primary care training may help address the primary care workforce shortage.
- Including primary care trainees in quality improvement has been linked to trainee satisfaction with primary care.
- Regular assessment of trainee knowledge is critical to adapting programs to address needs and capacity to serve in primary care settings. Improvement of knowledge reflects effectiveness of the training program vs. just the increase in the number of enrollments.
- Regular assessment of trainee satisfaction is critical to adapting programs to address needs and further foster a commitment to serve in primary care. Increased satisfaction helps with the sustainability of the project.

Project Components:

Through the Training of Community Health Workers (CHWs) Program, we propose to meet all required project components listed below.

a) Increase the number of community health workers/promotoras being trained and placed with healthcare teams, and

b)Training providers and clinic staff on how to integrate CHWs as members of the health care team.

For the Training of Community Health Workers (CHWs) Program, we have identified in the table below the milestones and metrics based upon the above project components and relationship to project goals and population needs.

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

The project represents a new initiative for UT Southwestern.

Unique Community Needs Assessed:

- CN.3 – Healthcare Capacity
- CN.4 – Primary Care
- CN.8 – Chronic Disease
- CN.12- Emergency Department Usage

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management
IT-1.7 Controlling high blood pressure

Reasons/rationale for selecting the outcome measures:

Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensive patients, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee. By expanding the number of Community Health Workers, more at-risk Medicaid and low income patients can have their blood pressure regularly screening and alerted to the need for seeing a primary care provider earlier.

Relationship to other Projects:

- ***126686802.1.1.2—Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care***

Clinics: This project improves access to primary care services by creating a robust Network of efficient, quality primary care physicians for RHP 9 patients. As community-based primary care physicians join the Network, they will no longer be practicing in "isolation". Through clinical integration with UT Southwestern faculty physicians, these community-based primary care physicians will engage in the continual development and implementation of clinical "best practice" protocols for the diseases treated by all Network physicians that are also responsible for the largest percentage of medical costs.

- ***126686802.1.1.4—Implement a Quality Incentive Program for Network Primary Care Providers:*** UTSCAP Primary Care Network clinics will be able to participate in a quality incentive program. However, their ability to participate in this quality incentive program will be dependent upon their enrollment and participation in the Medicaid program, creating an environment whereby primary care physicians see all populations as a viable part of a broader patient population management program.

- ***126686802.1.10.2—Implement UT Southwestern Population Management Infrastructure Development:*** UTSCAP Primary Care Network clinics will provide services to Network patients via a Network-wide population management infrastructure to improve quality and efficiency in the care they deliver.

- ***126686802.2.9.1—Implement/Expand Care Coordination Programs:*** UTSCAP Primary Care Network clinics will provide services to Network patients via access to the Network's care coordinators, ensuring that all Network patients receive coordinated, timely, and site-appropriate health care services.

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

Plan for Learning Collaborative:

The Anchor plans to develop and facilitate Learning Collaboratives in the Region with DFW Hospital Council. UT Southwestern will participate in the Collaborative(s) as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation:

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied

towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

This project's score for this criteria: 2.5 X 2 = **5**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

This project's score for this criteria: 2.5 X 2 = **5**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 3 X 2 = **6**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 3.5 X 2 = **7**

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 4 X 2 = **8**

Total Valuation Score for this project: **5.7**

These values are provided for in the table below and are allocated equally amongst the milestone

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126686802.1.10	*PROJECT OPTION* *1.2.2*	*PROJECT COMPONENT(S)* 1.2.2(a)-(b)	*TRAINING OF COMMUNITY HEALTH WORKERS (CHW'S)*	
UT Southwestern Medical Center Faculty Practice Plan				*TPI 126686802*
Related Category 3 Outcome Measure(s): **IT-1.7 Controlling high blood pressure**	***126686802.3.32***	***IT-1.7***	**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-1]: Conduct a primary care gap analysis to determine workforce needs. Metric 1.1 [P-1.1]: Gap assessment of workforce shortages Baseline: No assessment Goal: Submission of completed assessment Data Source: Assessment results **Milestone 1 Estimated Incentive Payment: $849,243** **Milestone 2** [P-2]: Expand primary care training for community health workers Metric 2.1 [P-2.1]: Expand other primary care staff (community health workers) training programs Baseline: UTSW currently doesn't have a CHW training program. Goal: Develop training program curriculum. Data Source: Training program documentation. **Milestone 2 Estimated Incentive**	**Milestone 3** [P-2]: Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists (CHWs) Metric 3.1 [P-2.2]: Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period. Baseline: Zero (0) preceptors Goal: Hire one preceptor. Data Source: HR documents, faculty lists, or other documentation **Milestone 3 Estimated Incentive Payment: $393,753** **Milestone 4** [P-3]: Expand positive primary care exposure for residents/trainees (CHWs) Metric 4.1 [P-3.2]: Train trainees in the medical home model, chronic	**Milestone 8** [P-2]: Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists (CHWs) Metric 8.1 [P-2.2]: Hire additional precepting primary care faculty members. Baseline: 1 preceptor Goal: Hire one preceptor above baseline. Data Source: HR documents, faculty lists, or other documentation **Milestone 8 Estimated Incentive Payment: $397,823** **Milestone 9** [I-11]: Increase primary care training and/or rotations Metric 9.1 [I-11.1]: Increase the number of primary care residents and/or trainees, as measured by percent change of class size over	**Milestone 13** [P-2]: Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists (CHWs) Metric 13.1 [P-2.2]: Hire additional precepting primary care faculty members. Baseline: 2 preceptor Goal: Hire one preceptor above baseline. Data Source: HR documents, faculty lists, or other documentation **Milestone 13 Estimated Incentive Payment: $340,846** **Milestone 14** [I-11]: Increase primary care training and/or rotations Metric 14.1 [I-11.1]: Increase the number of primary care residents and/or trainees, as measured by percent change of class size over

126686802.1.10	*PROJECT OPTION* *1.2.2*	*PROJECT COMPONENT(S)* 1.2.2(a)-(b)	*TRAINING OF COMMUNITY HEALTH WORKERS (CHW'S)*	
UT Southwestern Medical Center Faculty Practice Plan				*TPI 126686802*
Related Category 3 Outcome Measure(s): **IT-1.7 Controlling high blood pressure**	***126686802.3.32***	***IT-1.7***	**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)**
Payment: $849,243	Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels. Baseline: No existing training program Goal: Documentation of program Data Source: Curriculum, rotation hours, and/or patient panels assigned to resident/trainee **Milestone 4 Estimated Incentive Payment: $393,753** **Milestone 5** [P-3]: Expand positive primary care exposure for residents/trainees Metric 5.1 [P-3.3]: Include trainees/rotations in quality improvement projects Baseline: Number of trainees involved in quality improvement projects during baseline period. Goal: 3 trainees involved in quality improvement projects. Data Source: Curriculum and/or quality improvement project		baseline. Trainees may include physicians, mid-level providers, and/or other clinicians /staff. Baseline: Zero (0)CHWs – New class Goal: Enroll 5 CHWs in class. Data Source: Documented enrollment by class by year by primary care training program **Milestone 9 Estimated Incentive Payment: $397,823** **Milestone 10** [I-11]: Increase primary care training and/or rotations Metric 3.1 [I-11.5]: Improvement in trainee satisfaction with specific elements of the training program Baseline: New class – no satisfaction baseline Goal: Achieve 65% trainee satisfaction rating. Data Source: Trainee satisfaction assessment tool **Milestone 10 Estimated Incentive Payment: $397,823**	baseline. Trainees may include physicians, mid-level providers, and/or other clinicians /staff. Baseline: 5 CHWs in class Goal: Increase class size by 2 or more over baseline Data Source: Documented enrollment by class by year by primary care training program **Milestone 14 Estimated Incentive Payment: $340,846** **Milestone 15** [I-11]: Increase primary care training and/or rotations Metric 15.1 [I-11.5]: Improvement in trainee satisfaction with specific elements of the training program Baseline: 65% trainee satisfaction Goal: 5% increase over baseline in trainee satisfaction. Data Source: Trainee satisfaction assessment tool **Milestone 15 Estimated Incentive Payment: $340,846** **Milestone 16** [I-11]: Increase primary

126686802.1.10	*PROJECT OPTION* *1.2.2*	*PROJECT COMPONENT(S)* 1.2.2(a)-(b)	*TRAINING OF COMMUNITY HEALTH WORKERS (CHW'S)*	
UT Southwestern Medical Center Faculty Practice Plan				*TPI 126686802*
Related Category 3 Outcome Measure(s): **IT-1.7 Controlling high blood pressure**	***126686802.3.32***	***IT-1.7***	**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)**
	documentation/data **Milestone 5 Estimated Incentive Payment: $393,753** **Milestone 6** [P-8]: Establish /expand a faculty development program Metric 6.1 [P-8.1]: Enrollment of faculty staff into primary care education and training program Baseline: No existing enrollment Goal: Documentation of program and enrollment Data Source: Program documents **Milestone 6 Estimated Incentive Payment: $393,754** **Milestone 7** [P-9]: Develop /disseminate clinical teaching tools for primary care or interdisciplinary clinics/sites Metric 7.1 [P-9.1]: Clinical teaching tools Baseline: No existing teaching tools Goal: Submission of teaching tools Data Source: Enlist institutions that		**Milestone 11** [I-11]: Increase primary care training and/or rotations Metric 11.1 [I-11.6]: Improvement in trainee knowledge assessment scores Baseline: New class – no baseline scores. Goal: Mean score of class participants is 70%. Data Source: Knowledge assessment tool **Milestone 11 Estimated Incentive Payment: $397,823** **Milestone 12** [I-12]: Recruit/hire more trainees/graduates to primary care positions in performing Provider facilities Metric 12.1 [I-12.1]: Percent change in number of graduates /trainees accepting positions in the Performing Provider's facilities over baseline Baseline: Zero (0) graduates hired by Performing Providers Goal: Hire 3 graduates Data Source: Documentation, such as HR documents compared to class	care training and/or rotations Metric 16.1 [I-11.6]: Improvement in trainee knowledge assessment scores Baseline: Mean class score of 70%. Goal: Means score of class participants is 75%. Data Source: Knowledge assessment tool **Milestone 16 Estimated Incentive Payment: $340,846** **Milestone 17** [I-12]: Recruit/hire more trainees/graduates to primary care positions in performing Provider facilities Metric 17.1 [I-12.1]: Percent change in number of graduates /trainees accepting positions in the Performing Provider's facilities over baseline Baseline: 3 hired graduates Goal: Hire 2 graduates above baseline. Data Source: Documentation, such as HR documents compared to class lists

126686802.1.10	*PROJECT OPTION* *1.2.2*	*PROJECT COMPONENT(S)* 1.2.2(a)-(b)	*TRAINING OF COMMUNITY HEALTH WORKERS (CHW'S)*	
UT Southwestern Medical Center Faculty Practice Plan				*TPI 126686802*
Related Category 3 Outcome Measure(s): **IT-1.7 Controlling high blood pressure**	***126686802.3.32***	***IT-1.7***	**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)**
	provide clinical teaching as consultants. **Milestone 7 Estimated Incentive Payment: $393,754**		lists **Milestone 12 Estimated Incentive Payment: $397,824**	**Milestone 17 Estimated Incentive Payment: $340,846**
Year 2 Estimated Milestone Bundle Amount: $ 1,698,486	Year 3 Estimated Milestone Bundle Amount: $ 1,968,767		Year 4 Estimated Milestone Bundle Amount: $ 1,989,116	Year 5 Estimated Milestone Bundle Amount: $ 1,704,230
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* ***$ 7,360,599***				

Project Option: 1.9.2 – Improve access to specialty care services
Title of Project*:* UT Southwestern Medical Center: Establish/Expand Urgent Care Services for Cancer Patients

RHP Project Identification Number: 126686802.1.11 (Pass 2)
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW") Faculty Practice Plan/ TPI 126686802

Summary Information
Summary Description: This project will expand a pilot program that began in September 2012, creating an Urgent Care Clinic providing immediate access for the Simmons Cancer Clinic (SCC) patients experiencing acute symptoms or complications of treatment. The goal is to reduce ED visits, improve time-sensitive care, and streamline admissions to University Hospital St. Paul. A mid-level provider and a nurse, under the supervision of an oncologist, will staff the Urgent Care Service.

Provider*:* The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds in the St. Paul and Zale Lipshy Hospitals and 40 clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. In 2011, UTSW physicians provided care to Charity and Medicaid patients during 16,175 visits which were specifically at UT Southwestern outpatient practices.

Intervention: When cancer patients undergoing treatment experience complications and acute symptoms, they are usually referred to the ED or the go directly to the ED because their symptoms appear after clinic hours. By providing a triage nurse and an Urgent Care Service that is staffed with oncology-trained staff, most acute episodes can be treated without an expensive ED visit or inpatient admission. The Urgent Care Service will be expanded to include evenings, nights and weekends to be available whenever patients are in crisis.

Need for Project: The RHP 9 Community Needs Assessment shows that cancer patients represent most of the highest cost ED encounters for all payors in the Region. In addition, potential preventable admissions of cancer patients are among the most expensive admissions for all payors and all cateogries. The pilot project data showed that an Urgent Care Service for Cancer Patients could reduce avoidable ED visits and inpatient admissions by up to 80%. Cancer-related Medicaid and Uninsured inpatient encounter costs totaled $23,089,618 compared to the total cost for all payors of $86,421,715.

Target Population: All active patients being seen in the Simmons Cancer Center Clinic (SCCC) represent the entire target population. Approximately 4% of SCCC patients are Medicaid. Medicaid and low-income patients are more likely to resort to using the ED for the complications and acute symptoms.

Category 1 & 2 Expected Patient Benefits:

The new service can provide patients will immediate traige and initial treatment in under an hour, depending on where they live. In its first month of operation, the program prevented 48 ED visits and potentially 40 avoidable inpatient admissions, or at least 2 Medicaid ED visits and 1 Medicaid admission per month. That could avoid up to $100,000 in Medicaid costs and improve outcomes every month.

Category 3 Outcomes:
OD-9 Right Care, Right Setting; IT-9.2: ED appropriate utilization
OD-2 Potentially Preventable Admissions; IT-2.13: Other Admission Rates (complications of cancer treatment)

Project Description:
UT Southwestern operates the only NCI-designated Comprehensive Cancer Center in north Texas. Until recently, the Simmons Cancer Clinic (SCC) patients experiencing acute symptoms, whether due to their cancer, cancer treatment, or an unrelated illness, are referred to the University St. Paul Emergency Department (ED) for symptom management and resolution. From Fiscal Year 2011 to Fiscal Year 2012, the average number of ED visits grew 48%, from 40 ED encounters per month to 59 ED visits per month, largely due to increases in SCC patient volume growth.

This project will expand a pilot program that began in September 2012, creating an Urgent Care Clinic designed to provide immediate access for the Simmons Cancer Clinic (SCC) patients experiencing acute symptoms. The goal of the SCC Urgent Care Clinic is to reduce ED visits, improve time-sensitive care, and streamline admissions to University Hospital St. Paul, when appropriate, in a cost effective manner. The pilot program operates Monday through Friday during normal clinic hours, which are 8:00 a.m. to 5:00 p.m. A mid-level provider and a nurse, under the supervision of an oncologist, will staff the Urgent Care Service. Cancer patients undergoing active treatment for their condition who develop treatment-related and/or disease-related side effects will be referred by a triage nurse to the Urgent Care Clinic. The conditions could include fever, fatigue, nausea, anorexia, respiratory infection, sinusitis, mouth sores, vomiting, diarrhea, constipation, dehydration, hypovolemia, electrolyte imbalance, skin rash, neutropenia, and neuropathy. If the triage nurse determines that the patient should go directly to the ED, the triage nurse will coordinate the ED visit and treatment/care that the patient receives. Oncology specialists will work with ED physicians to determine if an admission is appropriate.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals:
The project goals are:

- Reduce the number of Simmons Cancer Clinic patients referred to, or going directly to, the ED (75% reduction during FY2013);

- Increase timeliness of care for call-in patients experiencing acute symptoms (1 hour or less time between telephone call and the time treatment is initiated, depending on where they live);
- Improve patient satisfaction regarding access to care;
- Improve the process for direct admission to the hospital, when inpatient admission is necessary.
- Extend Urgent Care Clinic hours to evenings and weekends, as determined by demand and need.

The project goals relate directly to, and strongly support, the Regional goals for

- improved access to care,
- improved care coordination and management, and
- improved provider performance and outcomes.

The project will address the following RHP 9 Community Needs Assessment priorities:

- CN.8 – Chronic Disease Management
- CN.9 – Access to Specialty Care
- CN.12 – Emergency Department (ED) Usage and Readmissions

While the number of cancer patients identified in the Community Needs Assessment is small (9,082 from Q3-2010 through Q3-2011), cancer patients rank in the top 3 to top 5 diagnoses for Highest Charge per Encounter for Medicaid and Uninsured patients (range from $1,593 to $10,692 per encounter). Admissions for cancer patients represent the Highest Charge per Encounter for all payor categories (range from $29,987 to $163,893).

Challenges:

The region has a well-defined health professions shortage. The challenge for this project is being able to recruit and train mid-level providers and nurses who understand both the side effects and complications associated with cancer treatment, as well as how to triage and treat acute symptoms in an urgent care setting. Another challenge is educating patients and their families that it is appropriate to call the Cancer Center's Urgent Care Services when acute symptoms are being experienced so that the patients can be triaged and directed for the right care in the right place in a timely manner. The third challenge for the Performing Provider is the rapid growth of the Simmons Cancer Center patient volume. This project will address these challenges by educating patients and their families in the management of side effects and

complications. As the pilot program proves its value, the SCC will recruit mid-level providers and nurses in advance of the need in order to assure adequate time to provide advanced training in the required skills to care for the acute cancer patient.

5-Year expected outcomes for Provider and Patients:

BY DY5, we expect to avoid up to 3,000 avoidable Emergency Department visits and 2,400 avoidable hospital admissions. We project that there would be approximately 90 avoidable ED visits and 72 avoidable hospital admissions for Medicaid patients. That translates into between $750,000 and $1,000,000 in immediately avoidable costs, significant improvement in outcomes and quality of life during cancer treatments. Data will be collected and evaluated to determine if the outcomes for patients who can avoid PPAs and HACs during the PPAs are better than those patients who resort to ED visits and PPAs. Patients benefiting per DY is estimated to be DY2 -500, DY3-750 DY4-850, DY5-900. For Medicaid patients alone, the avoidable costs alone would be over $4,000,000. Given the tendency for Medicaid patient ED utilization to be higher than other groups, the potential costs savings could be much higher. Quality of life and patient satisfaction will also be much higher for all populations.

Starting Point/Baseline:

The Simmons Cancer Center Urgent Care Services pilot began on September 1, 2012. The baseline will effectively be determined in DY2. DY1 data is comprised of just one month, which was the beginning of the pilot program start-up.

Rationale:

UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, UT Southwestern's Faculty Practice Plan is one of the providers for physician services in Texas. For example, between December 2010 and November 2011, UT Southwestern physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices.

The RHP 9 Community Needs Assessment shows that cancer patients represent most of the highest cost ED encounters for all payors in the Region. In addition, the CNA data shows that potential preventable admissions of cancer patients are among the most expensive admissions for all payors and all cateogries. The limited pilot project data suggests that an Urgent Care Service for Cancer Patients could reduce avoidable ED visits and inpatient admissions by up to 80%.

The Community Needs Assessment data shows that Medicaid and uninsured patients accounted for 371 of the 1,295 cancer-related inpatient admissions from the ED during the CNA data period. Cancer-related Medicaid and Uninsured inpatient encounter costs totaled $23,089,618 compared to the total cost for all payors of $86,421,715. Cancer-related Medicaid and Uninsured ED encounters costs, deatiled totaled $965,221 compared to $2,097,949 for all payors. Cancer-related ED encounters for Medicaid and uninsured patients totaled 188 out of the 359 ED encounters for all payors, according the DFW Hospital Council data in the CNA.

UTSW selected this project because access to urgent care services are limited for any condition, but is non-existent for Cancer patients. The new service, and the innovative model of urgent care, can provide patients will immediate traige and initial treatment in under an hour, depending on where they live. They could receive the right care, at the right time, in the right setting, avoiding unnecessary, expensive and disruptive ED visits and inpatient admissions.

When cancer patients undergoing treatment experience complications and acute symptoms, they are usually referred to the ED or the go directly to the ED because their symptoms appear after traditional clinic hours. All too often, the ED staff are not sufficiently familiar with the particular patient and admit the patient for treatment and monitoring of the patient's condition. By providing a triage nurse and an Urgent Care Service that is staffed with oncology-trained staff, most acute episodes can be treated without an expensive ED visit or inpatient admission. The Urgent Care Service will be expanded to include evenings, nights and weekends to be available whenever patients are in crisis.

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

The development of the new Urgent Care Service for Cancer Patients is a new initiative for UT Southwestern and the Simmons Cancer Center. The innovative model of meeting the urgent needs of patients within a traditional schedule-driven delivery system is an effort to transform the usual fragmented care delivery into a more coordinated delivery process. UTSW hopes that this model will be successful and can be duplicated in other ambulatory clinics across the UT Health System and in Region 9.

Community Needs Addressed:

The specific and unique community need identification numbers that this project addresses include the following:

- CN.3 - Healthcare Capacity
- CN.9 - Chronic Disease
- CN.12 - Emergency Department Usage and Readmissions

Related Category 3 Outcome Measure(s):

OD-9 Right Care, Right Setting
IT-9.2 ED appropriate utilization
OD-2 Potentially Preventable Admissions
IT-2.13 Other Admission Rates (complications of cancer treatment)

Reasons/rationale for selecting the outcome measures:

Preventable ED visits and preventable inpatient admissions significantly disrupt the treatment plan and continuum of care for cancer patients. Being able to receive both routine care and

urgent care from the same highly-skilled clinical team would improve patient satisfaction, improve outcomes, and reduce the cost of care. The two chosen measures reflect the goal of the project which is to reduce potentially preventable ED encounters and inpatient visits.

Relationship to other Projects: This project relates to one other proposed project in terms of improving access, capacity and performance across all specialty care settings. The specific projects include:

126686802.1.5 Expand specialty care capacity

Relationship to Other Performing Providers' Projects in the RHP:
There are six other Category 1.9 projects in the RHP 9 Plan for Pass 1 to expand access to specialty care, include project being proposed by Baylor Medical Center at Carrolton, Baylor Medical Center at Garland, Baylor Medical Center at Irving, Baylor University Medical Center, CMC of Dallas, Parkland Health and Hospital System, Texas Scottish Rite. The list for Pass 2 projects has not been released.

Plan for Learning Collaborative: The Anchor plans to develop and facilitate Learning Collaboratives in the Region. UT Southwestern will participate in the Collaboratives as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation:
The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

This project's score for this criteria: 9.00

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

This project's score for this criteria: 8.00

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 9.00

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 9.00

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 9.00

Total Valuation Score for this project: **8.30**

126686802.1.11	*PROJECT OPTION 1.9.2*	*COMPONENTS 1.9.2.(A-D)*	*UT Southwestern Clinical Center:* **Establish and Expand Access to Urgent Care – Urgent Care Cancer Services**	
The University of Texas Southwestern Medical Center				**TPI 126686802**
Related Category 3 Outcome Measures:	*126686802.3.33* *126686802.3.34*	*IT-2.13* *IT-9.2*	Other admission rates – admission rate for cancer patients ED appropriate utilization	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct specialty care gap assessment based on community need. **Metric [P-1.1]:** Documentation of gap assessment. **Goal**: Document the need for urgent care services for cancer patients. **Data Source**: RHP 9 Community Needs Assessment, UTSW EHR reports, hospital reports, UT Select claims data, DFW Hospital data, demographic reports. **Milestone 1 Estimated Incentive Payment:** $455,539 **Milestone 2** [P-12]: Implement a specialty care access plan to include statement of problem, background and methods, findings, implications of findings, conclusion. **Metric** [12.1]: Documentation of specialty care access plan. **Data Source**: Needs assessment, provider plan, budget and staffing projections. **Goal**: Plan that will outline what it will take to develop and expand urgent care services for	**Milestone 7 [**I-22**]:** Increase the number of specialty care providers and staff available for triage and referral of patients to the Urgent Care Service. **Metric** [I.22.1.1] Increase number of specialist providers Numerator: Number of specialist staff and providers hired and trained to work in Urgent Care Service. Denominator: Total number of staff and providers. **Data Source:** HR data; Log of specialty care personnel hired and trained. **Goal**: Hire an additional mid-level provider and nurse to staff triage line and care for patients during expanded hours. **Milestone 7 Estimated Incentive Payment:** $358,350 **Milestone 8 [**I-22**]:** Increase the number of Urgent Care Service Clinic hours.	**Milestone 15 [**I-22**]:** Increase the number of specialty care providers and staff available for triage and referral of patients to the Urgent Care Service. **Metric** [I.22.1.1] Increase number of specialist providers Numerator: Number of specialist staff and providers hired and trained to work in Urgent Care Service. Denominator: Total number of staff and providers. **Data Source:** HR data; Log of specialty care personnel hired and trained. **Goal**: Hire an additional mid-level provider and nurse to staff triage line and care for patients during expanded hours. **Milestone 15 Estimated Incentive Payment:** $321,826 **Milestone 16 [**I-22**]:** Increase the number of Urgent Care Service Clinic hours.	**Milestone 24 [**I-24**]:** Implement specialty urgent care access programs in other clinics **Metric** [I.24.1] Number of primary care and medical specialty clinics with urgent care access programs. Numerator: Number of primary care and medical specialty clinics with urgent care access programs. Denominator: Total number of primary care and specialty care clinics. **Data Source:** Documentation of policies and procedures for urgent care access in other clinics **Goal**: Export the model of urgent care specialty services to 1 additional clinic. **Milestone 24 Estimated Incentive Payment:** $275,733 **Milestone 25 [**I-22**]:** Increase the number of Urgent Care Service Clinic hours. **Metric** [I-22.1.1] Increase number of Urgent Care Service (UCS) hours.

126686802.1.11	*PROJECT OPTION 1.9.2*	*COMPONENTS 1.9.2.(A-D)*	*UT Southwestern Clinical Center:* **Establish and Expand Access to Urgent Care – Urgent Care Cancer Services**	
The University of Texas Southwestern Medical Center				**TPI 126686802**
Related Category 3 Outcome Measures:	*126686802.3.33* *126686802.3.34*	*IT-2.13* *IT-9.2*	Other admission rates – admission rate for cancer patients 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)**
cancer patients. **Milestone 2 Estimated Incentive Payment:** $445,539 **Milestone 3 [**P-2**]:** Train care providers and staff on processes, guidelines for triage and referral of patients to the Urgent Care Service. **Metric** [P-2.1] Training of staff and providers Numerator: Number of staff and providers trained. Denominator: Total number of staff and providers. **Data Source:** Log of specialty care personnel trained. **Goal**: Train all staff directly involved in Urgent Care Service. **Milestone 3 Estimated Incentive Payment**: $445,539 **Milestone 4 [**P-3**]:** Collect baseline data for call volume, wait times between call and treatment, backlog, referrals to ED and SPUH.	**Metric** [I-22.1.1] Increase number of Urgent Care Service (UCS) hours. Numerator: Number of hours above previous year. Denominator: Total number of hours triage and treatment is available in UCS. **Data Source:** Clinic schedule, staffing schedule. **Goal**: Expand Urgent Care by at least 10 hours per week. **Milestone 8 Estimated Incentive Payment:** $358,350 **Milestone 9** [I-23] Increase urgent care services volume of visits and evidence of improved access for patients seeking services. **Metric** [I-23.1]: Documentation of increased number of visits. **Baseline:** Total volume of visits in DY2. **Data Source:** EHR reports, other documentation, claims data, call volume reports. **Goal**: Increase volume of visits by 20%.		**Metric** [I-22.1.1] Increase number of Urgent Care Service (UCS) hours. Numerator: Change in the number of hours above previous year. Denominator: Total number of hours triage and treatment was available in previous year. **Data Source:** Clinic schedule, staffing schedule. **Goal**: Expand Urgent Care by at least 10 hours per week. **Milestone 16 Estimated Incentive Payment:** $321,826 **Milestone 17** [I-23] Increase urgent care services volume of visits and evidence of improved access for patients seeking services. **Metric** [I-23.1]: Documentation of increased number of visits. Numerator: Change in the number of visits above previous year. Denominator: Total number of visits in previous year. **Baseline:** Total volume of visits in DY3. **Data Source:** EHR reports, other	Numerator: Change in the number of hours above previous year. Denominator: Total number of hours triage and treatment was available in previous year. **Data Source:** Clinic schedule, staffing schedule. **Goal**: Expand Urgent Care by at least 10 hours per week. **Milestone 25 Estimated Incentive Payment:** $275,733 **Milestone 26** [I-23] Increase urgent care services volume of visits and evidence of improved access for patients seeking services. **Metric** [I-23.1]: Documentation of increased number of visits. Numerator: Change in the number of visits above previous year. Denominator: Total number of visits done in previous year. **Baseline:** Total volume of visits in DY4. **Data Source:** EHR reports, other documentation, claims data, call volume reports.

126686802.1.11	*PROJECT OPTION 1.9.2*	*COMPONENTS 1.9.2.(A-D)*	*UT Southwestern Clinical Center:* **Establish and Expand Access to Urgent Care – Urgent Care Cancer Services**	
The University of Texas Southwestern Medical Center				**TPI 126686802**
Related Category 3 Outcome Measures:	*126686802.3.33* *126686802.3.34*	*IT-2.13* *IT-9.2*	Other admission rates – admission rate for cancer patients ED appropriate utilization	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric [P-3.1]: Establish baseline for performance indicators. Numerator: Based on indicator Denominator: Total population subject to indicator **Goal:** Documentation for all baseline data. **Data Source:** EHR reports, other documentation **Rationale:** Indicators determine effectiveness of plan, staff training, staff ratios, patient education about using Urgent Care. **Milestone 4 Estimated Incentive Payment**: $445,539 **Milestone 5**[P-6]: Develop and implement standardized triage referral guidelines. **Metric** [P-6.1]: Referral and triage guidelines documented. Goal: Documented referral and triage guidelines. Data Source: Referral and triage policies and procedure documents. **Milestone 5 Estimated Incentive**	**Milestone 9 Estimated Incentive Payment:** $358,350 **Milestone 10** [I-12]: Increase number of unique patients. **Metric [**I-12.2**]:** Documentation of unique visits. **Baseline:** Baseline volume of unique patients from DY2. **Data Source:** EHR reports, other documentation **Rationale:** This measures the increased volume of patients on the panel and is a method to assess the ability to increase capacity to provide care. **Goal:** Increase panel size by 10% over previous year. **Milestone 10 Estimated Incentive Payment:** $358,350 **Milestone 11** [I-27]: Patient satisfaction with Urgent Care Services. **Metric [**I-27.1**]:** Patient satisfaction	documentation, claims data, call volume reports. **Goal**: Increase volume of visits by 10%. **Milestone 17 Estimated Incentive Payment:** $321,826 **Milestone 18** [I-12]: Increase number of unique patients. **Metric [**I-12.2**]:** Documentation of unique visits. Numerator: Change in the number of unique patients above previous year. Denominator: Total number of unique patients in previous year. **Baseline:** Baseline volume of unique patients from DY2. **Data Source:** EHR reports, other documentation **Rationale:** This measures the increased volume of patients on the panel and is a method to assess the ability to increase capacity to provide care. **Goal:** Increase panel size by 10% over previous year.	**Goal**: Increase volume of visits by 10%. **Milestone 26 Estimated Incentive Payment:** $275,733 **Milestone 27** [I-12]: Increase number of unique patients. **Metric [**I-12.2**]:** Documentation of unique visits. Numerator: Change in the number of unique patients above previous year. Denominator: Total number of unique patients in previous year. **Baseline:** Baseline volume of unique patients from DY2. **Data Source:** EHR reports, other documentation **Goal:** Increase panel size by 10% over previous year. **Milestone 27 Estimated Incentive Payment:** $275,733 **Milestone 28** [I-27]: Patient satisfaction with Urgent Care Services.

126686802.1.11	*PROJECT OPTION 1.9.2*	*COMPONENTS 1.9.2.(A-D)*	***UT Southwestern Clinical Center:* Establish and Expand Access to Urgent Care – Urgent Care Cancer Services**	
The University of Texas Southwestern Medical Center				**TPI 126686802**
Related Category 3 Outcome Measures:	*126686802.3.33* *126686802.3.34*	*IT-2.13* *IT-9.2*	Other admission rates – admission rate for cancer patients 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)**
Payment: $445,539 **Milestone 6**[P-9]: Implement referral technology and processes that enable improved and more streamlined provider communication. **Metric** [P-9.1]: Documentation of referral technology and processes, particular between triage staff, SCC providers, ED and SPUH admissions. Goal: Documentation for referral process and communication guidelines. Data Source: Referral process documentation. Rationale: A streamlined process will improve timely access to the right care at the right place and time. **Milestone 6 Estimated Incentive Payment**: $445,539	scores. **Baseline:** DY2 patient satisfaction scores. Numerator: Sum of all survey scores. Denominator: Number of surveys completed. Data Source: Press-Ganey surveys or other evidence-based survey tool. Rationale: Feedback improves ability to target improvements in services. Goal: Increase satisfaction score by 1% over previous year. **Milestone 11 Estimated Incentive Payment:** $358,350 **Milestone 12** [I-27]: Patient satisfaction with Urgent Care Services. **Metric [**I-27.2**]:** Percentage of Patients receiving surveys. Baseline: DY2 survey rate. Numerator: Number of survey distributed during DY3 Denominator: Total number of	**Milestone 18 Estimated Incentive Payment:** $321,826 **Milestone 19** [I-27]: Patient satisfaction with Urgent Care Services. **Metric [**I-27.1**]:** Patient satisfaction scores. **Baseline:** DY2 patient satisfaction scores. Numerator: Sum of all survey scores. Denominator: Number of surveys completed. Data Source: Press-Ganey surveys or other evidence-based survey tool. Rationale: Feedback improves ability to target improvements in services. Goal: Increase satisfaction score by 1% over previous year. **Milestone 19 Estimated Incentive Payment:** $321,826 **Milestone 20** [I-27]: Patient	**Metric [**I-27.1**]:** Patient satisfaction scores. **Baseline:** DY2 patient satisfaction scores. Numerator: Sum of all survey scores. Denominator: Number of surveys completed. Data Source: Press-Ganey surveys or other evidence-based survey tool. Rationale: Feedback improves ability to target improvements in services. Goal: Increase satisfaction score by 1% over previous year. **Milestone 28 Estimated Incentive Payment:** $275,733 **Milestone 29** [I-27]: Patient satisfaction with Urgent Care Services. **Metric [**I-27.2**]:** Percentage of Patients receiving surveys. Baseline: DY2 survey rate. Numerator: Number of survey distributed during DY3

126686802.1.11	*PROJECT OPTION 1.9.2*	*COMPONENTS 1.9.2.(A-D)*	***UT Southwestern Clinical Center:* Establish and Expand Access to Urgent Care – Urgent Care Cancer Services**	
The University of Texas Southwestern Medical Center				**TPI 126686802**
Related Category 3 Outcome Measures:	*126686802.3.33* *126686802.3.34*	*IT-2.13* *IT-9.2*	Other admission rates – admission rate for cancer patients 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)**
	visits to Urgent Care Service. Data Source: Documentation of survey distribution. Goal: 75% of patients visiting Urgent Care Service receive surveys. **Milestone 12 Estimated Incentive Payment:** $358,350 **Milestone 13** [I-27]: Patient satisfaction with Urgent Care Services. **Metric [**I-27.3**]:** Response rate to patient satisfaction surveys. Baseline: DY2 survey response rate. Numerator: Number of survey responses. Denominator: Total number of surveys distributed. Data Source: Documentation of survey distribution, EHR. Rationale: The more feedback, the more accurate the results and ability to improve services. Goal: Increase response rate by 10%.	satisfaction with Urgent Care Services. **Metric [**I-27.2**]:** Percentage of Patients receiving surveys. Baseline: DY2 survey rate. Numerator: Number of survey distributed during DY3 Denominator: Total number of visits to Urgent Care Service. Data Source: Documentation of survey distribution. Goal: 80% of patients visiting Urgent Care Service receive surveys. **Milestone 20 Estimated Incentive Payment:** $321,826 **Milestone 21** [I-27]: Patient satisfaction with Urgent Care Services. **Metric [**I-27.3**]:** Response rate to patient satisfaction surveys. Baseline: DY2 survey response rate. Numerator: Number of survey responses. Denominator: Total number of	Denominator: Total number of visits to Urgent Care Service. Data Source: Documentation of survey distribution. Goal: 80% of patients visiting Urgent Care Service receive surveys. **Milestone 29 Estimated Incentive Payment:** $275,733 **Milestone 30** [I-27]: Patient satisfaction with Urgent Care Services. **Metric [**I-27.3**]:** Response rate to patient satisfaction surveys. Baseline: DY2 survey response rate. Numerator: Number of survey responses. Denominator: Total number of surveys distributed. Data Source: Documentation of survey distribution, EHR. Rationale: The more feedback, the more accurate the results and ability to improve services. Goal: Increase response rate by 6%.

126686802.1.11	*PROJECT OPTION 1.9.2*	*COMPONENTS 1.9.2.(A-D)*	*UT Southwestern Clinical Center:* **Establish and Expand Access to Urgent Care – Urgent Care Cancer Services**	
The University of Texas Southwestern Medical Center				**TPI 126686802**
Related Category 3 Outcome Measures:	*126686802.3.33* *126686802.3.34*	*IT-2.13* *IT-9.2*	Other admission rates – admission rate for cancer patients 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 13 Estimated Incentive Payment: $358,350 **Milestone 14** [P-20]: Review Project Data and respond to it every week with tests of new ideas, practices, tools or solutions. **Metric [**P-20.1**]:** Number of new ideas, practices, tools or solutions tested by each provider. Goal: At least 46 Weekly meetings to review data and test new ideas, tools. Data Source: Brief description of the idea, practice, tool or solution tested each week by each provider. **Milestone 14 Estimated Incentive Payment:** $358,351	surveys distributed. Data Source: Documentation of survey distribution, EHR. Rationale: The more feedback, the more accurate the results and ability to improve services. Goal: Increase response rate by 6%. **Milestone 21 Estimated Incentive Payment:** $321,826 **Milestone 22** [P-20]: Review Project Data and respond to it every week with tests of new ideas, practices, tools or solutions. **Metric [**P-20.1**]:** Number of new ideas, practices, tools or solutions tested by each provider. Data Source: Brief description of the idea, practice, tool or solution tested each week by provider. Goal: Increase number of items tested by 5%. **Milestone 22 Estimated Incentive Payment:** $321,825	**Milestone 30 Estimated Incentive Payment:** $275,733 **Milestone 31** [P-20]: Review Project Data and respond to it every week with tests of new ideas, practices, tools or solutions. **Metric [**P-20.1**]:** Number of new ideas, practices, tools or solutions tested by each provider. Data Source: Brief description of the idea, practice, tool or solution tested each week by each provider. Goal: Increase number of items tested by 5%. **Milestone 31 Estimated Incentive Payment:** $275,733 **Milestone 32 [**I-22**]:** Increase the number of specialty care providers and staff available for triage and referral of patients to the Urgent Care Service. **Metric** [I.22.1.1] Increase number of specialist providers

126686802.1.11	*PROJECT OPTION 1.9.2*	*COMPONENTS 1.9.2.(A-D)*	*UT Southwestern Clinical Center:* **Establish and Expand Access to Urgent Care – Urgent Care Cancer Services**	
The University of Texas Southwestern Medical Center				**TPI 126686802**
Related Category 3 Outcome Measures:	*126686802.3.33* *126686802.3.34*	*IT-2.13* *IT-9.2*	Other admission rates – admission rate for cancer patients 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 23 [I-24**]:** Implement specialty urgent care access programs in other clinics **Metric** [I.24.1] Number of primary care and medical specialty clinics with urgent care access programs. Numerator: Number of primary care and medical specialty clinics with urgent care access programs. Denominator: Total number of primary care and specialty care clinics. **Data Source:** Documentation of policies and procedures for urgent care access in other clinics **Goal**: Export the model of urgent care specialty services to 1 additional clinic. **Milestone 23 Estimated Incentive Payment:** $321,825	Numerator: Number of specialist staff and providers hired and trained to work in Urgent Care Service. Denominator: Total number of staff and providers. **Data Source:** HR data; Log of specialty care personnel hired and trained. **Goal**: Hire an additional mid-level provider and nurse to staff triage line and care for patients during expanded hours. **Milestone 32 Estimated Incentive Payment:** $275,733
Year 2 Estimated Milestone Bundle Amount**: $2,673,234**	Year 3 Estimated Milestone Bundle Amount: **$2,866,801**		Year 4 Estimated Milestone Bundle Amount: **$2,896,432**	Year 5 Estimated Milestone Bundle Amount: **$2,481,597**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* **$10,918,064**				

Project Option: 1.10.2 Enhance improvement capacity through technology
Title of Project: A Health System Quality Improvement Center at UT Southwestern

Unique RHP Project Identification Number: 126686802.1.12 (Pass 2)
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW") Faculty Proactice Plan/TPI 126686802

Summary Information

Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds 452-beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, an average of 24% of UTSW patient visits were attributed to Medicaid patients across Parkland, Children's and UT Southwestern.

Intervention(s): This project will implement the development of a comprehensive center involved with data reporting, methodologies of quality improvement, and systems re-engineering of health care delivery at UT Southwestern ("Quality Improvement Center").

Need for the project: UT Southwestern has a robust quality improvement program that is effective but it lacks the cutting edge expertise in systems engineering and quality metrics analysis and reporting.

Target population: The target population is all patients seen at UT Southwestern University Hospitals and Clinics including all Medicaid and indigent patients. Our hospital attributes days serving patient at 11% for Medicaid (i.e. based on weighted patient days), while our faculty clinical practice population is comprised of approximately 3% Medicaid and indigent patients. Thus, we expect at least 11% of the benefits of the Quality Improvement Center to impact Medicaid and/or indigent patients.

Category 1 or 2 expected patient benefits: The project seeks to provide health care delivery re-engineering and data reporting capabilities to providers and patients of UT Southwestern.

Category 3 outcomes:

- IT-3.1 All cause 30 day readmission rate - Our goal is to reduce the 30-day potentially preventable all-cause readmission rate by 5% over the DY2 baseline by DY5.

Title of Project: A Health System Quality Improvement Center at UT Southwestern

Unique RHP Project Identification Number: 126686802.1.12 (Pass 2)

Performing Provider Name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW") Faculty Proactice Plan/TPI 126686802

Project Summary:

Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds 452-beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, an average of 24% of UTSW patient visits were attributed to Medicaid patients across Parkland, Children's and UT Southwestern.

Intervention(s): This project will implement the development of a comprehensive Quality Improvement Center involved with data reporting, methodologies of quality improvement, and systems re-engineering of health care delivery at UT Southwestern ("Quality Improvement Center"). By generating more data, more performance activities will be initiated, resulting in cost avoidance and outcomes improvements.

Need for the project: UT Southwestern has a robust quality improvement program that is effective but it lacks the cutting edge expertise in systems engineering and quality metrics analysis and reporting.

Target population: The target population is all patients seen at UT Southwestern University Hospitals and Clinics including all Medicaid and indigent patients. Our hospital attributes days serving patients at 11% for Medicaid (i.e. based on weighted patient days), while our faculty clinical practice population is comprised of approximately 3% Medicaid and indigent patients. Thus, we expect at least 11% of the benefits of the Quality Improvement Center to impact Medicaid and/or indigent patients. In absolute numbers, 11% of hospital days of 20,000 discharges will be attributed to Medicaid and charity as well as 3% of 750,000 outpatient visits (22,500 visits). Based on the other projects being proposed for RHP 9, the target population will increase over the next 4 years, and beyond.

Category 1 or 2 expected patient benefits: The project seeks to provide health care delivery re-engineering and data reporting capabilities to providers and patients of UT Southwestern.

Category 3 outcomes:

- IT-3.1 All cause 30 day readmission rate - Our goal is to reduce the 30-day potentially preventable all-cause readmission rate by 5% over the DY2 baseline by DY5. Generating more quality data and dashboards will lead to new ways to achieve this outcome.

Project Description:

This project describes the development of a UT Southwestern quality data management and systems engineering group that will provide expertise to our hospitals and clinics in the area of industrial and systems engineering improvement methods to improve patient safety, operational efficiency, access to care and costs. Our health system already has some expertise in Lean and Six Sigma methodologies, but this group will provide more expertise in other cutting edge methodologyies of industial, systems and human factors engineering. We plan to recruit recruit industrial, systems and human factors engineers that will work with our quality improvement projects to apply systems engineering improvement science to major healthcare processes and develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement. The Quailty Improvement Center will also develop interdisciplinary courses for healthcare professionals, students, post graduate trainees, engineers and administrative healthcare leadership.

In addition, the project will develop quality improvement capacity at UT Southwestern assisting the Strategic Planning Office in developing quality improvement dashboards through the Quality Improvement Center that will integrate quality improvement (QI) data from various institutions and national reporting agencies, measure, report monthly specialty specific data, and serve as the engine to drive, conduct and rapidly diffuse quality and patient safety improvements. Through these reports, UT Southwestern will support on-going quality improvement projects and promote patient safety culture change with rapid diffusion of key successful process between departments and hospitals.

The population served will include all patients seen in the UT Southwestern University Hospitals and Clinics. This includes over 20,000 hospital discharges per year in two University Hospitals and over 700,000 ambulatory visits in the University's clinic system. The Center will provide dashboards, reporting and analytics for all publically reported clinical process and outcome metrics including quality, patient safety and patient satisfaction data. The metrics will include, but not be limited to, CMS Core Measure, Patient Safety Indicators, Hospital Associated Conditions, Hospital Associated Infctions, Patient Satisfaction, Never Events, readmissions, and mortality. The metrics will be measurable at the individual provider level which will also include clinical process and outcome measures for diseases identified as high risk and utilization . Our hospitals attributes days at 11% for Medicaid and charity (i.e. based on weighted patient days), while our faculty clinical practice population is comprised of approximately 3% Medicaid and indigent patients. Thus, we expect at least 11% of the benefits of the Quality Improvement Center to impact Medicaid and/or indigent patients. In absolute numbers, 11% of hospital days of 20,000 discharges will be attributed to Medicaid and charity as well as 3% 0f 750,000 outpatient visits (22,500 visits).

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goal and Relationship to Regional Goals:

The goals of this project are to (1) expand quality improvement capacity throughout UT Southwestern so that we are able to conduct, report, drive and measure quality improvement and (2) implement process improvement methodologies at UT Southwestern to improve safety, quality, efficiency and access to care. These goals are strongly related to the Regional goals of not only providing more access to care, but to provide more access to quality care.

Challenges:

UTSW has been challenged with: 1) high rates of preventable hospital admissions, 2) high rates of preventable hospital readmissions, and 3) high rates of some preventable complications of hospitalization. These have in part due to the high acuity of UTSW University Hospital patients, but the high rates persist even after risk adjstment for acuity.

Implementation: 1) Recruitment and retention of systems engineers. 2) Training of systems users. This project will assist in our current clinical transformation at UT Southwestern that has put quality and patient safety as its primary mission. Potentially preventable hospital admissions, readmissions, and hospital complications are high profile measures of the quality of care provided by an institution and this project will improve that quality.

5-Year Expected Outcome for Provider and Patients:

Our hospitals attributes days at 11% for Medicaid and charity (i.e. based on weighted patient days), while our faculty clinical practice population is comprised of approximately 3% Medicaid and indigent patients. Thus, we expect at least 11% of the benefits of the Quality Improvement Center to impact Medicaid and/or indigent patients. In absolute numbers, 11% of hospital days of 20,000 discharges will be attributed to Medicaid and charity as well as 3% 0f 750,000 outpatient visits (22,500 visits). Successful establishment of a quality data and systems engineering center, i.e. the Quaity Improvement Center, creation of quality improvement dashboards and improvement in care delivery processes leading to decrease in potentially preventable readmissions and complications of hospitalization, cost avoidance and improved patient outcomes. Based on the other projects being proposed for RHP 9, the target population will increase over the next 4 years, and beyond.

Starting Point/Baseline:

UTSW currently has an Office of Quality Improvement and safety with 10 employees involved in quality improvement training and some data analysis. This project will primarily be to start an re-engineering componenet to our quality improvement activities and exapnd out analytic capability to include predictive modeling.

Rationale:

Performance improvement and reporting is a very large component of success of all of the project areas across the DSRIP project categories. Two of the drivers for significant transformation of health care delivery will be accurate, actionable data and re-engineering of

the processes of health care delivery. The Institute of medicine defines the quality of medical care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"(To Err is Human, 2000, Institute of Medicine). According to the Institute of Medicine (IOM), the majority of medical errors result from faulty systems and processes, not individuals. Because errors are caused by system or process failures, it is important to adopt various process improvement techniques to identify inefficiencies, ineffective care, and preventable errors to then influence changes associated with systems. This project seeks to implement the process changes necessary at UT Southwestern that will drive improved quality and safety.

Project Components:

This group will work through the office of Quality Improvement and Safety at UT Southwestern to meet the following required project components:

a) Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.

b) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.

c) Design data collection systems to collect real-time data that is used to drive continuous quality improvement

For this project we have chosen the following milestones and metrics:

Unique community need identification numbers the project addresses:

- CN.9 (High rates of preventable hospital readmissions)
- CN.10 (High rates of preventable hospital admissions)
- CN.11 (Patient Safety and Quality)

How the project represents a new or significantly enhances an existing delivery system reform initiative: Current we do not have re-engineering expertise in the form of trained industrial or human factors engineers. This project will add that expertise. We currently have analysts involved in quality reporting functions but this project will add significant capability for advanced analytics and predictive modeling.

Related Category 3 Outcome Measure(s):

IT-3.1 All cause 30 day readmission rate

Reasons/rationale for selecting the outcome measures: This project will improve many areas of health care delivery in our systems. We chose the outcome measure of 30 day readmissions because that is one area that where UTSW currently scores below average by University Health System Consortium metrics.

Relationship to other Projects:

This project's focus on creating the Quality Improvement Center at UT Southwestern is strongly tied to all our Category 1 and 2 projects because we cannot increase access or capacity without the simultaneous pursuit of quality. The following projects are samples of our Category 1 and 2 related to the implementation of the Quality Improvement Center:

- 126686802.2.3—Redesigning for Cost Containment
- 126686802.1.1—Expand existing primary care capacity
- 126686802.2.1—Enhance/Expand Medical Homes
- 126686802.1.2—Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics

- 126686802.1.3—Implement a Quality Incentive Program for Network Primary Care Providers

- 126686802.1.4—Implement UT Southwestern Population Management Infrastructure Development

- 126686802.2.1—Expanding the Medical Home Model in the UTSCAP Primary Care Network

- 126686802.1.7—Implement telemedicine program
- 126686802.2.2—Applying process improvement methodology to improve quality and efficiency by training in the methodology of quality improvement

- 126686802.2.5—Expanding Care Transition Programs

Plan for Learning Collaborative:

The Anchor plans to develop and facilitate Learning Collaboratives in the Region with DFW Hospital Council. UT Southwestern will participate in the Collaborative(s) as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation:

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following

exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

This project's score for this criteria: 4.5 X 2 = 9

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

This project's score for this criteria: 4.5 X 2 = 9

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 3.88 X 2 = 7.75

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 4.5 X 2 = 9

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 4.5 X 2 = 9

Total Valuation Score for this project: **8.3**

These values are provided for in the table below and are allocated equally amongst the milestones

126686802.1.12	***PROJECT OPTION 1.10.2***	***CORE PROJECT COMPONENTS 1.10.2(A-C)***	Health System Quality Improvement Center at UT Southwestern	
The University of Texas Southwestern Medical Center Faculty Practice				126686802
Related Category 3 Outcome Measure(s):	126686802.3.35	*IT-3.1*	*All cause 30 day 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)**
Milestone 1 [P-1]: Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the UT Physicians's delivery system Metric 1.1 [P-1.1]: Documentation of the establishment of performance improvement office Baseline: No previous office. Goal: Establish the Performance Improvement Office Data source: Identified space, office policies and procedures, goals and objectives. **Milestone 1 Estimated incentive payment: $ 1,332,368** **Milestone 2** [P-6]: Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends)	Milestone 3 [P-6]: Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends) Metric 3.1 [P-6.1]: Increase number of staff trained in quality and efficiency improvement principles Baseline: 1 staff in DY2 Goal: 5 engineers or persons trained as Black Belt Lean or Six Sigma Data Source: Training records Milestone 3 Estimated incentive payment: $ 714,238 Milestone 4 [I-7]: Implement quality improvement data systems, collection, and reporting capabilities Metric 4.1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems Baseline: Zero previous regular		**Milestone 7** [I-7]: Implement quality improvement data systems, collection, and reporting capabilities Metric 7.1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems Baseline: 6 regular reports produced in DY3 Goal: Generate **12** regular reports of quality metrics Data Source: Quality improvement data systems documentation/reports **Milestone 7 Estimated incentive payment: $ 962,160** **Milestone 8** [I-7]: Implement quality improvement data systems, collection, and reporting capabilities Metric 8.1 [I-7.2]: Demonstrate how regular quality reports drive process improvement – Number of performance improvement activites that were designed and implemented with data from the reports. Baseline: DY3 activities, if any. Goal: 3 performance	**Milestone 10** [I-8]: Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures Metric 10.1 [I-8.1]: Submission of quality dashboard or scorecard Baseline: 4 Dashboard in DY4 Goal: 6 Dashboard reports Data Source: Quality improvement data systems documentation/reports **Milestone 10 Estimated incentive payment: $ 824,357** **Milestone 11** [I-7]: Implement quality improvement data systems, collection, and reporting capabilities Metric 11.1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems Goal: Generate 10 regular reports of quality metrics Data Source: Quality improvement data systems documentation/reports

126686802.1.12	***PROJECT OPTION 1.10.2***	***CORE PROJECT COMPONENTS 1.10.2(A-C)***	Health System Quality Improvement Center at UT Southwestern	
The University of Texas Southwestern Medical Center Faculty Practice				126686802
Related Category 3 Outcome Measure(s):	126686802.3.35	*IT-3.1*	*All cause 30 day 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)**
Metric 2.1 [P-6.1]: Increase number of staff trained in quality and efficiency improvement principles Baseline: Zero Goal: Hire at least 1 peson as an experienced, trained office manager. Data Source: HR employment records; Training records **Milestone 2 Estimated incentive payment: $ 1,332,369**	reports. Goal: Generate **6** regular reports of quality metrics Data Source: Quality improvement data systems documentation/reports Milestone 4 Estimated incentive payment: $ 714,238 Milestone 5 [I-8]: Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures Metric 5.1 [I-8.1]: Submission of quality dashboard or scorecard template for approval Baseline: Zero for DY2 Goal: Established Quality Dashboard for all academic departments at UTSW Data Source: Quality improvement data systems documentation/reports Milestone 5 Estimated incentive payment: $ 714,238		improvement activities are developed using data from the reports. Data Source: Quality improvement data systems documentation/reports **Milestone 8 Estimated incentive payment: $ 962,160** **Milestone 9** [I-8]: Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures Metric 9.1 [I-8.1]: Submission of quality dashboard or scorecard Baseline: 2 Quality Dashboards Goal: 4 Quality Dashbaords distributed to all Departments. Data Source: Quality improvement data systems documentation/reports **Milestone 9 Estimated incentive payment: $ 962,161**	**Milestone 11 Estimated incentive payment: $ 824,357** **Milestone 12** [I-7]: Implement quality improvement data systems, collection, and reporting capabilities Metric 12.1 [I-7.2]: Demonstrate how regular quality reports drive process improvement – Number of performance improvement activites that were designed and implemented with data from the reports. Baseline: 3 Performance Acivities reported. Goal: 6 performance improvement activities are developed using data from the reports. Data Source: Quality improvement data systems documentation/reports **Milestone 12 Estimated incentive payment: $ 824,358**

126686802.1.12	***PROJECT OPTION 1.10.2***	***CORE PROJECT COMPONENTS 1.10.2(A-C)***	Health System Quality Improvement Center at UT Southwestern	
The University of Texas Southwestern Medical Center Faculty Practice				126686802
Related Category 3 Outcome Measure(s):	126686802.3.35	*IT-3.1*	*All cause 30 day 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)**
	Milestone 6 [I-8]: Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures Metric 6.1 [I-8.1]: Produce Quality Dashboard Reports for Academic Departments Baseline: Zero – no previous Dashboards produced. Goal: Produce and distribute at least 2 cycles of Dashboards for all Departments during DY3 Data Source: Quality improvement data systems documentation/reports Milestone 6 Estimated incentive payment: $ 714,238			
Year 2 Estimated Milestone Bundle Amount: $2,664,737	Year 3 Estimated Milestone Bundle Amount: $2,856,952		Year 4 Estimated Milestone Bundle Amount: $2,886,481	Year 5 Estimated Milestone Bundle Amount: $2,473,072
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $10,881,242				

Project Option: 1.9.3 Implement other evidence-based project to expand specialty care capacity in an innovative manner not described in the project options above.
Title of Project: Expanding specialty care capacity by providing access to bone marrow and solid organ transplants for patients with inadequate funding.

Unique Project ID: 175287501.1.1 (Pass 2)
Performing Provider Name/TPI: The University of Texas Southwestern University Hospitals/ 175287501

Summary Information

Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds 452-beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, an average of 24% of UTSW patient visits were attributed to Medicaid patients across Parkland, Children's and UT Southwestern.

Intervention(s): This project will implement a mechanism for underfunded patients who need solid organ and bone marrow transplants to be evaluated and receive transplant if qualified.

Need for the project: Currently the patients frequently do not receive evaluation for needed transplant leading to frequent hospitalizations and premature death.

Target population: The target population is all patients in North Texas who are referred to UT Southwestern Medical Center that need evaluation for transplant but have inadequate funding.

Category 1 or 2 expected patient benefits: The project seeks to increase specialty access and treatment for patients currently not offered the service in many cases. By DY5, we project an additional 88 targeted patients will be referred to the UT Southwestern Transplant Program, 31 patients will be listed for transplant, and 20 targeted patients will receive transplants.

Category 3 outcomes:
OD-4 Potentially preventable complications
IT-4.2 Central line-associated bloodstream infection rates

IT-1.20 Other-Outcomes of solid organ and bone marrow transplantation

Project Description:

Currently, indigent and Medicaid patients, especially managed Medicaid, are less likely to receive needed bone marrow, heart, lung and liver transplants when compared to matched patients with funding through Medicare or commercial insurance (King, et al, 2005). Despite contributing significantly to the donation of organs and tissue for transplantation, these patients do not, many times, receive these life-saving procedures because of a lack of adequate funding. Certain funding programs such as traditional Medicaid may fund part of the cost of the transplant but many of these patients then lack the resources or funding for expensive post-transplant care, including immunosuppressive medications. This lack of resources causes many patients to be declared ineligible by transplant programs. We propose a program to address this disparity by offering these transplant services to medically eligible indigent and Medicaid patients through our current transplant programs.

Our plan is to evaluate all patients referred to UT Southwestern for transplantation from North Texas. Patients with no or inadequate transplant and post-transplant funding will be covered by this project. Currently, unfunded patients are not offered solid organ transplants at a North Texas Center. UT Southwestern has a large and successful solid organ and bone marrow transplant program. The number of patients who have been evaluated, listed and transplanted in this program over the past few years are listed in Exhibit 1.

For this project, patients who meet transplant criteria will be listed for transplantation regardless of transplant of post-transplant funding status. Since the number of patients who will eventually be transplanted will depend on organ availability and allocation - which is not controlled by the transplanting team or organization - total transplant number of unfunded patient will not under the control of the provider. However, we have estimated the number of transplants that will result from the number of listings. Listed patients, funded and unfunded, will receive transplant using current clinical criteria. Using our current ratios of evaluated to listed and eventual transplanted patients, we expect to see the following number of unfunded or underfunded patients in this project:

	DY2	DY3	DY4	DY5
Number of referrals	0	5	30	40
Patients listed	0	2	10	15
Transplanted	0	0	10	10

Exhibit 1: Transplant Operating Statistics by Fiscal Year

	FY10	FY11	FY12	3 Year Total
Referrals:				
Heart	150	138	148	**436**
Lung	150	229	254	**633**
Kidney*	348	326	340	**1,014**
Kidney	240	243	332	**815**

Liver ** including El Paso*	127	259	328	**714**

Evaluations:

Heart	39	61	94	**194**
Lung	30	75	120	**225**
Kidney*	252	197	218	**667**
Kidney	142	175	216	**533**
Liver ** including El Paso*	69	153	200	**422**

Waitlist Additions:

Heart	37	28	27	**92**
Lung	31	46	83	**160**
Kidney	69	106	77	**252**
Liver	24	49	88	**161**

Transplants:

Heart	22	24	26	**72**
Lung	24	36	60	**120**
Kidney	37	28	38	**103**
Liver	11	15	41	**67**

Sustainability of this project will be address by the end of DY5. UT Southwestern will remain committed to caring for these patients after the project is completed. We will work with the Dallas County Hospital District, Medicaid and other payors to maintain adequate funding for these transplanted patients after the DSRIP funding ceases.

Collaboration

This project is one of two projects being proposed through a collaboration agreement. The specific collaboration arrangement specific to this project is set forth below.

Collaborators	DY2	DY3	DY4	DY5	Total
Parkland Memorial Hospital	3,395,195	3,521,210	3,764,879	4,094,434	14,775,718
Project / Collaboration	**DY2**	**DY3**	**DY4**	**DY5**	**Total**
Category 1 Project Value	3,037,806	3,106,950	3,100,136	2,504,830	11,749,722
Related Category 3	357,389	414,260	664,743	1,589,604	3,025,996

Projects Value					
Total Project Value	**3,395,195**	**3,521,210**	**3,764,879**	**4,094,434**	**14,775,718**

The collaboration involves the transfer of Pass 2 allocated dollars from Parkland Memorial Hospital (public entity) to the performing provider (public entity). The combined project value for this project equals the funding provided by the collaborating entity.

The collaborating parties have joined together in this collaboration with the belief that the goals of this project are valuable and will contribute to regional transformation.

Goal and Relationship to Regional Goals:

The goal of this project is to address a major disparity in access to specialty care for patients with inadequate funding.

Challenges:

Providing this service to medically eligible patient poses significant challenges to UT Southwestern as it would for any transplant program. Solid organ and bone marrow transplantations have substantial costs which include the initial evaluation, the transplant procedure, recovery, rehabilitation, and long term follow up with immunosuppressive therapy. Complications of the transplant and immunosuppression therapy can also be very costly. In addition, many uninsured patients who have temporary funding for the transplant do not have coverage for the long-term immunosuppression therapy which is very costly.

This project addresses these challenges by providing adequate funding to evaluate potential candidates then transplant and provide follow up care that is not available through other funding sources if a transplant is deemed appropriate.

5-Year Expected Outcome for Provider and Patients:

The project seeks to increase specialty access and treatment for patients currently not offered the service in many cases. By DY5, we project an additional 88 targeted patients will be referred to the UT Southwestern Transplant Program, 31 patients will be listed for transplant, and 20 targeted patients will receive transplants. The milestone and outcome metrics for the project are consistent with standard outcomes for transplant patients with other funding sources. The key improvement in DY4 and DY5 will be the 1-year survival of patients who are transplanted in the underfunded group which will be the same as for funded patients. The Category 3 outcome will examine the number of central line-associated infections in these patients after transplantation. This outcome is key to improving survival rates.

Starting Point/Baseline:

UT Southwestern is a nationally recognized center for solid organ and bone marrow transplantation services with mature programs involving heart, lung, kidney, liver, and bone marrow procedures. The UT Southwestern solid organ and bone marrow transplant program has outcomes for these services that rank in the top tier of the United States. The number of

referrals, evaluations, candidate listings, and transplants in each of these categories is listed in exhibit 1. This project proposes to increase the number in all of these categories by adding patients who lack funding or are underfunded. The metrics will be conservative given the fact that transplantation depends on many factors including the suitability of referred patients for transplantation by medical criteria, availability of organs for transplantation and social issues that could affect the candidate.

Rationale:

This project seeks to address this disparity by offering transplants to any suitable eligible patient regardless of funding. Evidence has shown that recipients of heart, liver and bone marrow transplants have a reduced cost of care and certainly have better mortality and quality of life outcomes than patients with advanced heart and liver failure and some hematologic malignancies treated with medical interventions without transplantation (Jarl and Gerdtham, 2011). This program addresses this disparity. The metrics and milestones chosen represent standard measures of patient evaluation, number of transplants and outcomes.

The targets selected for the milestones and metrics of this project were selected taking into account the variability of referred patients with respect to their suitability and criteria for transplantation. The first two years will focus primarily on attracting suitable referrals to the transplantation programs. The second two years will focus on the number of transplants and clinical outcomes of patients who are transplanted. Milestone 1 will be a customized milestone to document a gap analysis of the number or proportion of underfunded patient who are not offered the possibility of transplantation as a treatment option. We have estimated the number of transplants metric since most of the waiting list additions are later in this project and time on the waiting list is relatively unpredictable. Historically, we have transplanted approximately 60% of listed patients.

Unique community need identification numbers the project addresses:

- CN.1 Community Overview and Description
- CN.3 Healthcare Capacity
- CN.8 Chronic Disease
- CN.9 Specialty Care

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

This project significantly enhances the UT Southwestern transplant center's ability to expand access to specialty care, i.e. transplant services, to a segment of our population that currently does not have access to these live-saving services.

Related Category 3 Outcome Measure(s):
The outcome measures for this program will include one standalone Category 3 Outcome Measure relating to complications of transplantation and one nonstandalone measure unique to this project .

OD-4 Potentially preventable complications
IT-4.2 Central line-associated bloodstream infection rates

IT-1.20 Other-Outcomes of solid organ and bone marrow transplantation

Reasons/rationale for selecting the outcome measure:
The central line-associated blood stream infection rate was chosen because central line infections are a complication of the immunosuppression and the high number of central line days in these patients. This complication adds significant risk to the patient in terms of morbidity and mortality and adds significant cost to the treatment of transplant patients.

The mortality outcome is an outcome measure tailored to this project. The measure will be the 1-year survival of all patients, including indigent and Medicaid patients, undergoing the transplant services at UT Southwestern. This is a standard measure used by transplant programs to assess the clinical effectiveness. The goal will be for these underfunded patients to have the same 1-year survival rates as the general transplant population in our region. The description of how this metric will be calculated and compared to regional averages is described in the category 3 Project.

Relationship to other Projects:
This project is very unique and focused on addressing a major disparity by **expanding access to specialty care** for patients requiring a solid organ or bone marrow transplant who have inadequate funding.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
This project is unique to RHP 9. However, addressing this disparity in access to solid organ and bone marrow transplants is expected to alleviate the burden on RHP 9's safety-net hospitals for caring for these patients.

Project Valuation:
The valuation of this project takes into account two factors. First, the number of patients that need to be evaluated to result in one transplant was considered. The cost of this evaluation is significant and must be borne by the performing provider when outside funding does not exist. The cost of the transplant and recovery with follow up care was also considered. In addition, the number of patients who need bridging with a VAD (ventricular assistance device) was considered for the heart transplant patients. Finally, the possible avoidable cost of recurrent hospitalizations for chronic conditions precipitating the consideration for transplant for the patients, especially if the program is later scaled to a larger population, was an important factor

if community and future medical costs are considered. Patients with severe chronic liver disease, congestive heart failure and chronic lung disease who would be considered for transplant utilize inpatient services in the form of recurrent hospitalizations to stabilize their chronic condition. Transplantation offers the advantage over medical treatment of these patients of decreasing the need for recurrent hospitalization and improving overall quality of life (Jarl and Gerdtham, 2011).

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

   This project's score for this criteria: 4.5 X 2 = 9

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

   This project's score for this criteria: 4.5 X 2 = 9

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

   This project's score for this criteria: 4.5 X 2 = 9

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 5 X 2 = 10

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 4.84 X 2 = 9.67

Total Valuation Score for this project: 8.80

These values are provided for in the table below and are allocated equally amongst the milestones

175287501.1.1	*1.9.3*	*1.9.3 Other*	Expanding specialty care capacity by providing access to bone marrow and solid organ transplants for patients with inadequate funding.
The University of Texas Southwestern University Hospitals			175287501
Related Category 3 Outcome Measure(s):	*IT 4.2* *IT 1.20*	*175287501.3.1* *175287501.3.7*	Central Line-associated bloodstream infection rates Other-Outcomes of solid organ and bone marrow transplantation

Year 2 (10/1/2012 – 9/30/2013)	**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]: Perform and document gap analysis of disparity in availability of transplants to underfunded patients with medical conditions treatable with solid organ or bone marrow transplantation. Metric 1.1 [P-X.1]: Documentation of gap assessment. Baseline/Goal: Documentation of the disparity in availability of transplants to underfunded patients with medical conditions treatable with solid organ or bone marrow transplantation Data Source: Needs Assessment and community demographic data. Rationale/Evidence: In order to identify gaps in high-demand specialty areas to best build up supply of specialists to meet demand for services and improve specialty care. **Milestone 1 Estimated Incentive Payment** *:* $1,012,602 **Milestone 2** (I-29): Increase the	**Milestone 4** (I-29): Increase the number of referrals of targeted patients to the specialty care Clinic (UTSW Transplant Program). Metric 4.1[I-29.1]: Targeted referral rate Baseline: DY2 Referral Rate Goal: 15 referrals of targeted patients Data Source: Registry and/or paper documentation as designated by Performing Provider **Milestone 4 Estimated Incentive Payment:** $1,035,650 **Milestone 5** [I-X]: Increase the number of eligible, targeted patients listed for transplant. Metric 5.1 [I-X.1]: Targeted transplant list rate. Baseline: Number of targeted patients listed in DY3 Goal: 5 eligible, targeted patients listed for transplant. Data Source: Documentation by provider and transplant registry	**Milestone 7** [I-29]: Increase the number of referrals of targeted patients to the specialty care Clinic. Metric 7.1 [I-29.1]: Targeted referral rate Baseline: DY3 Referral Rate Goal: 30 referrals of targeted patients Data Source: Registry and/or paper documentation as designated by Performing Provider **Milestone 7 Estimated Incentive Payment:** $775,034 **Milestone 8** [I-X]: Increase the number of eligible, targeted patients listed for transplant. Metric 8.1 [I-X.1]: Targeted transplant list rate. Baseline: Number of targeted patients listed in DY3 Goal: 10 eligible, targeted patients listed for transplant. Data Source: Documentation by provider and transplant registry Rationale/Evidence: Number of	**Milestone 11** [I-29]: Increase the number of referrals of targeted patients to the specialty care Clinic. Metric 11.1 [I-29.1]: Targeted referral rate Baseline: DY4 Referral Rate Goal: 40 referrals of targeted patients Data Source: Registry and/or paper documentation as designated by Performing Provider **Milestone 11 Estimated Incentive Payment:** $626,207 **Milestone 12** [I-X]: Increase the number of eligible, targeted patients listed for transplant. Metric 12.1 [I-X.1]: Targeted transplant list rate. Baseline: DY4 Targeted Transplant List Rate Goal: 15 eligible, targeted patients listed for transplant. Data Source: Documentation by provider and transplant registry Rationale/Evidence: Number of listed eligible patients proportional to number of eventual transplants

175287501.1.1	***1.9.3***	***1.9.3 Other***	Expanding specialty care capacity by providing access to bone marrow and solid organ transplants for patients with inadequate funding.	
The University of Texas Southwestern University Hospitals				175287501
Related Category 3 Outcome Measure(s):	*IT 4.2* *IT 1.20*	*175287501.3.1* *175287501.3.7*	Central Line-associated bloodstream infection rates Other-Outcomes of solid organ and bone marrow transplantation	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
number of referrals of targeted patients to the specialty care Clinic (UTSW Transplant Program). Metric 2.1[I-29.1]: Targeted referral rate Baseline: Referral Rate from 2012 Goal: 3 referrals of targeted patients Data Source: Registry and/or paper documentation as designated by Performing Provider **Milestone 2 Estimated Incentive Payment:** $1,012,602 **Milestone 3** [I-X]: Increase the number of eligible, targeted patients listed for transplant. Metric 3.1 [I-X.1]: Targeted transplant list rate. Baseline: Number of targeted patients listed in DY3 Goal: 1 eligible, targeted patients listed for transplant. Data Source: Documentation by provider and transplant registry Rationale/Evidence: Number of		Rationale/Evidence: Number of listed eligible patients proportional to number of eventual transplants **Milestone 5 Estimated Incentive Payment:** $1,035,650 **Milestone 6** [I-X]: Increase the number of eligible, targeted patients transplanted. Metric 6.1 [I-X.1]: Targeted number of transplants. Baseline: DY3 Number of Targeted Patients Transplanted Goal: 2 transplants Data Source: Documentation by provider and transplant registry Rationale/Evidence: Number of eligible patients transplanted is eventual desire outcome **Milestone 6 Estimated Incentive Payment:** $1,035,650	listed eligible patients proportional to number of eventual transplants **Milestone 8 Estimated Incentive Payment:** $775,034 **Milestone 9** [I-X]: Provide same level of care to targeted patients as non-targeted patients. Metric 9.1 [I-X.1]: 1 year survival of all transplanted patients Baseline: DY3 Survival Rate Goal: Equal to national average and/or survival rates of Medicare and other insured patients of equal severity. Data Source: Documentation by provider and transplant registry Rationale/Evidence: Standard transplant quality metric **Milestone 9 Estimated Incentive Payment:** $775,034 **Milestone 10** [I-X]: Increase the number of eligible, targeted patients transplanted. Metric 10.1 [I-X.1]: Targeted number	**Milestone 12 Estimated Incentive Payment:** $626,208 **Milestone 13** [I-X]: Provide same level of care to targeted patients as non-targeted patients. Metric 13.1 [I-X]: 1 year survival of all transplanted patients. Baseline: DY4 Survival Rates Goal: Equal to national average and/or survival rates of Medicare and other insured patients of equal severity. Data Source: Documentation by provider and transplant registry Rationale/Evidence: Standard transplant quality metric **Milestone 13 Estimated Incentive Payment:** $626,208 **Milestone 14** [I-X]: Increase the number of eligible, targeted patients transplanted. Metric 14.1 [I-X.1]: Targeted number of transplants. Baseline: DY4 Number of Targeted Patients Transplanted

175287501.1.1	***1.9.3***	***1.9.3 Other***	Expanding specialty care capacity by providing access to bone marrow and solid organ transplants for patients with inadequate funding.	
The University of Texas Southwestern University Hospitals				175287501
Related Category 3 Outcome Measure(s):	*IT 4.2* *IT 1.20*	*175287501.3.1* *175287501.3.7*	Central Line-associated bloodstream infection rates Other-Outcomes of solid organ and bone marrow transplantation	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
listed eligible patients proportional to number of eventual transplants **Milestone 3 Estimated Incentive Payment:** $1,012,602			of transplants. Baseline: DY3 Number of Targeted Patients Transplanted Goal: 8 transplants Data Source: Documentation by provider and transplant registry Rationale/Evidence: Number of eligible patients transplanted is eventual desire outcome **Milestone 10 Estimated Incentive Payment:** $775,034	Goal: 10 transplants Data Source: Documentation by provider and transplant registry Rationale/Evidence: Number of eligible patients transplanted is eventual desire outcome **Milestone 14 Estimated Incentive Payment:** $626,027
Year 2 Estimated Milestone Bundle Amount: $3,037,806	**Year 3 Estimated Milestone Bundle Amount:** $3,106,950		**Year 4 Estimated Milestone Bundle Amount:** $3,100,136	**Year 5 Estimated Milestone Bundle Amount:** $2,504,830
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $11,749,722				

D. Category 2: Program Innovation and Redesign

Project Option 2.2.2 – Expand Chronic Care Management Model - Chronic Disease Management and Prevention Program

RHP Project Identifier: 195018001.2.1
Performing Provider/TPI: Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton/195018001

Provider: Baylor Medical Center at Carrollton is a 235-bed acute care facility located in Carrollton. The medical staff is comprised of over 500 physicians representing more than 50 specialties. Baylor Carrollton is a full service hospital providing comprehensive diagnostic, surgical, and medical care for inpatients and outpatients, as well as 24-hour emergency care. Baylor Carrollton's service area represents a population of 592,000.

Intervention(s): The project purpose is to provide focused education and point of care testing for underserved patients who have diabetes, CVD and/or Respiratory disease that are in need of education, clinical management and training within a primary care setting. We will co-locate primary care and chronic disease management services to improve clinical outcomes.

New v. existing initiative: This will be a new project, providing chronic disease education and management services to the Medicaid and Uninsured populations in Carrollton.

Need for the project: One of the major identified by the Community Health Needs Assessment for Region 9 included Chronic Disease. Components of patient education and helping patients to understand their illness, how to better manage it, how to coordinate their lifestyle choices and offering point of care testing in order to achieve optimal health outcomes are essential in population management of chronic disease

Target population: Approximately (estimated) 78,000 individuals in Denton County have Diabetes. 134,000 people have Asthma and CHF accounts for about 178 deaths per 100,000 individuals in Denton County.
Category 1 or 2 expected patient benefits: The project seeks provide chronic disease management and point of care testing services to 176 patients in DY4 and DY5.

Category 3 outcomes: The Baylor Clinic at Carrollton will be a new clinic, therefore the metric baseline and projected achievements are estimates based off of historical performance from other Baylor Clinics.

- IT-1.10: Diabetes Care: HbA1c Poor Control. Our goal is to decrease the number of patients with uncontrolled HbA1cs (> 9.0%) in DY4 to < 23.8% and < 22.6% in DY5 (or minimum of 1.2% improvement over baseline).

- IT-11.1: Diabetes Care: BP Control (< 140/80 mmHg). Our goal is to increase the number of diabetic patients in good BP control (< 140/80 mmHg) to 53.4% in DY4; 55.7% in DY5 (or minimum of 2.3% improvement over baseline).

- IT-1.13: Diabetes Care: Foot Exam. Our goal is to increase the number of diabetic patients who receive foot exams to 96.4% in DY4 and 96.8% in DY5 (or minimum of 1.4% improvement over baseline).

Project Description

The Baylor Clinic on the Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton campus, will be operational in DY4. As part of the services we will offer to the community, the clinic will house a carved out chronic disease management program to provide focused and dedicated education and care for patients with Diabetes, Cardiovascular Diseases (CVD) (i.e.: Congestive Heart Failure) and Respiratory Diseases (Asthma/Chronic Obstructive Pulmonary Disease) within a primary care setting. Specific staff, comprised of CHWs/Nurse Care Managers, would address the complex clinical and prevention needs of these patients and spend time specifically on management of these diseases. The focus of this time and education with patients would not only entail clinical counseling, but also include prevention components to focus on lifestyle issues and self-management. The other key advantage that patients will receive as part of this program is point of care testing for Diabetes (HbA1c testing and glucose testing using test strips) and Asthma (Peak Flow Meter Assessments). We believe this will overcome the barrier of patients' non-compliance with completing lab orders and any financial or transportation issues that would arise in obtaining these important lab results.

We plan to leverage the expertise and experience of both the Diabetes Health and Wellness Institute (Baylor entity in South Dallas) and Baylor Clinics to provide staff education, develop competencies, and create protocols that will result in a complete and robust program tailored for multiple community settings. The Diabetes Health and Wellness Institute would house this staff and appropriately triage and manage providers to see patient at Baylor Clinics based on volume and demand parameters. Baylor Clinics have had previous success in managing patients with chronic disease through the creation and development of a community health worker model (CHW). These successes and competencies will be leveraged to create programs around CVD and Respiratory illnesses. The Clinic on the Carrollton campus will begin seeing patients in DY4 and the Chronic Disease program will be launched simultaneously.

Goals and Relationship to Regional Goals

The project goals for this program include: 1) creating a baseline of chronic disease management availability in the Carrollton area, 2) increasing health literacy around chronic illnesses for patients in the community, 3) teaching self-management techniques for patients to manage their chronic diseases, and 4) increasing the number of patients who are screened and monitored for their chronic diseases using point of care testing (in DY4 and DY5). The purpose for performing a project in this area is to help identify patients with chronic diseases and provide them with treatment and education in a proactive fashion so that downstream

complications can be avoided and ED/inpatient utilization can decrease. There is no program like this offered in the Carrollton area which focuses on all three major chronic diseases and the underserved population.

One of the major issues identified by the Community Health Needs Assessment for Region 9 is Chronic Disease.[176] Components of patient education and helping patients to understand their illness, how to better manage it and how to coordinate their lifestyle choices to achieve optimal health outcomes are essential in population management of chronic disease. This project coincides with this need and focuses on education, lifestyle management, proactive counseling and decision making and clinical improvement. This leads to lower ED visits for acute issues related to chronic diseases and helps patients utilize costly services in the Region. Because this program will begin in DY4, we expect to see some positive affects during the waiver period.

Challenges

Until the Baylor Clinic is operational in DY4, we will not know the disease severity and state of the patients in the community until they begin coming to the clinic. The focus and scope of the program may need to be modified depending on community need and propensity to participate. Overall, underserved patients experience multiple barriers to effectively manage their chronic illnesses. These include lack of knowledge, lack of social support, poor diets, insufficient physical activity, and limited access to care due to financial and transportation issues. By co-locating the chronic care management program within the primary care clinic, patients can receive medical care and chronic disease support at the same time. Additionally, the PCP's medical management is informed by the chronic care management team's interactions with the patient, which, in our experience, elicits new information regarding lifestyle and barriers to health. The RN/CHW model will be structured so that patient education is delivered in a format and context that is understandable and enjoyable for the patient. Lastly, the education and counseling will include lifestyle and self-management techniques so that this population can find ways to care for themselves that is relevant to their daily lives.

5-year Expected Outcome for Provider and Patients

The expected 5-year outcomes are that: 1) a chronic disease management program will be established and functional by the end of the waiver period, 2) at least 176 patients will have served by the Chronic Care Management model at the Baylor Clinic, 2) we expect to begin to improve clinical outcomes around HbA1c, foot exam completion and BP control, 3) begin point of care testing for patients in the community, 4) increase literacy in the community around chronic diseases.

Starting Point/Baseline

There is no established baseline for this project. It is a new initiative on the Baylor Medical Center at Carrollton, where we will be establishing a new primary care clinic to care for the underserved population in Carrollton/Denton County. We estimated a target population based on the Community Health Needs Assessment. 11.4% of all Dallas County residents have

[176] RHP 9 Community Health Needs Assessment

diabetes. Using this percentage, applied to the Denton County population, equates to almost 78,000 individuals in the county. Literature shows that diabetes is more prevalent in the underserved community.[177] 19.6% of Dallas County has Asthma, which equates to 134,000 people in Denton County. CHF accounts for about 178 deaths per 100,000 individuals in Denton County.[178] These statistics do not take into consideration any intersection of CHF, Asthma and Diabetes which makes individuals more complex and high risk. [179] Our project will serve approximately 176 new patients of this population.

Rationale

The prevalence of chronic disease in the underserved population. As we establish our new Baylor Clinic on the Baylor Carrollton campus, we anticipate that chronic disease prevalence and related issues will be high. In order to proactively manage these patients and their conditions, we are proposing to begin the chronic disease management program simultaneously with the clinic. Through co-locating primary care and chronic disease management services, we can improve clinical outcomes. By increasing the availability of chronic care services and utilizing a team based approach, more patients can receive focused attention for their complex needs and learn to self-manage their illnesses in an effective way. We have demonstrated statistically significant reductions in mean HbA1c measures with a CHW model currently embedded in Baylor Clinics[180]. Thus expanding the educational services to serve more diabetes patients, and beginning to serve CHF and Asthma/COPD patients is a logical next step in improving the care of the population. The Community Health Needs Assessment identified the top 5 most prevalent conditions as: stroke, diabetes, CHF, failing kidneys and AMI. This project addresses 2 of these illnesses directly and 2 indirectly, it aligns exactly with the needs of the Region and the challenges that have been identified.[181]

Project Components

There are no additional core components to this project: 2.2.2 Apply evidence-based care management model to patients identified as having high-risk health care needs. We will engage in continuous quality improvement activities throughout the duration of the project such as: 1) identifying key challenges with the expansion of this project, 2) determine opportunities to scale all or part of the project- depending on available resources and financial constraints, 3) find ways to continuously integrate the chronic disease management program into the care team as much as possible.

The Chronic Care Management metrics and milestones we have chosen focus on finding the appropriate model that would be effective in Denton County for a start-up practice. We anticipate that the model will also address multiple chronic illnesses and the complex needs of this patient population. Because this program is part of a new clinic start up plan, we structured

[177] RHP 9 Community Health Needs Assessment

[178] Healthy People North Texas: http://www.healthyntexas.org

[179] Healthy People North Texas: http://www.healthyntexas.org

[180] Walton, J, Snead, C. et.al. Reducing diabetes disparities through implementation of a community health worker led diabetes self-management education program. Journal of Family and Community Health. 2012: 35(2): 161-71.

[181] RHP 9 Community Health Needs Assessment

our metrics to focus on increasing access, awareness and education for individuals in the region and some modest clinical improvement as well. We believe it will take time for patients to understand and epitomize good self-management behaviors and it will also take times to see marked clinical outcome improvements. We do anticipate some clinical improvement for those patients engaged in the chronic care management program for an extended period of time.

Unique community need identification number the project addresses: CN.8 Chronic Disease

How the Project significantly enhances an existing delivery system reform initiative We currently do not receive any federal funding for chronic disease education and providing services for CHF and Asthma/COPD are new to the Baylor Clinic. This project coincides with the need to focus on chronic illnesses, as they are the main drivers of health care costs in the US. Diabetes alone costs the US almost $174 billion dollars a year. [182]

Related Category 3 Outcome Measures

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

Outcome Measure #1: IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (**Standalone measure**). In Dallas County, more than 11.4% of the population has a diagnosis of Diabetes with more than 32% of the population classified as obese and at risk for developing Diabetes[183]. Traditionally, the underserved population does not have access to the necessary medications, education and supplies to manage their diabetes, thus many times patients go undiagnosed or have poor glucose control. This project would facilitate timely and appropriate care for those with diabetes and ensure that regular labs and point of care testing is completed to monitor results and make appropriate interventions. We expect that at least 5-7% of patients that are seen regularly in a Baylor Clinic will have improved HbA1c levels. Bodenheimer, et al., found that patient self-management of chronic disease conditions, such as diabetes, that was co-located in a primary care setting led to significant improvement in HbA1c control in patients[184]. A recent of edition of Managed Care found that patients with an HbA1c > 9 had on average almost $5000 worth of hospitalization costs, while those with an HbA1c of < 7 had about $2700 in hospitalization costs[185]. Focusing efforts on increasing improvement of good glycemic control will result diminishing in other co-morbid conditions and improve complication rates for these patients. Because patients will begin being seen I nDY4, we expect only modest improvement in HbA1c. Our projections may need to be modified depending on the severity of illness and disease state that our patients present with.

[182] http://www.diabetes.org/diabetes-basics/diabetes-statistics/

[183] RHP 9 Community Health Needs Assessment

[184] Bodenheimer, T., Lorig, K.., Holman, H., Grumbach, K. Patient Self-management of Chronic Disease in Primary Care *JAMA* (May 15, 2008).

[185] MenzinJ, Korn, J, Cohen, J, et.al Relationship between glycemic control and diabetes related hospital costs in patients with type 1 or type 1 diabetes mellitus. J Manag Care Pharm. 2010; 16(4):264-275.

Outcome Measure #2: T-1.11 Diabetes care: BP control (<140/80mm Hg) – NQF 0061 (**Standalone measure**). At Baylor Health Care System, blood pressure control and management is a required part of the diabetes care in order to avoid other co-morbid conditions such as heart disease and stroke. A 2010 study in the New England Journal of Medicine by Cushman, et. al showed that better and less severe health outcomes related to cardiovascular episodes and stroke were achieved with tight blood pressure control in diabetic patients[186]. Events that would be fatal with higher blood pressure became nonfatal under better blood pressure control in these studies completed. As part of an outpatient, clinic based protocol, blood pressure control can be achieved in patients who will come to the Baylor Clinic. Again, similar to HbA1c, we expect modest improvement in BP in years DY4 andDY5 contingent upon patient participation in the clinic and chronic disease program. Our primary goal will be to have patients come in for basic services and chronic disease education.

Outcome Measure #3: IT-1.13 Diabetes care Foot exam- NQF 0056 (**Non- standalone measure**). An innovative part of this project is that the educators (CHWs and RN Care Managers) will be able to conduct diabetic foot exams as part of patient education session. This will increase the rate of screening and allow providers to identify issues such as ulcers and nerve issues earlier and more often. Foot exams are a low cost, highly effective way to avoid costly interventions such as wound care and management, amputations, neuropathy and other complex issues.. It is recommended by the American Diabetes Association that diabetic patients receive yearly foot exams to determine if there are predisposing factors for ulceration and amputation[187].

Relationship to other Projects

195018001.1.1: Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved. This chronic care management project is related because: 1) services will be co-located and 2) the chronic care and primary care teams will be integrated

Related Category 4 Population-focused improvements

RD-1.1, RD-1.2, RD-1.4, RD-1.5, RD-2.1, RD-2.2, RD-2.4, RD-2.5, RD-2.7, RD-3.1, RD-3.2, RD-3.3, RD-3.4, RD-3.5, RD-3.6, RD-3.8, RD-3.10, RD-3.11, RD-3.12, RD-3.13, RD-3.14, RD-3.15, RD-3.24, RD-3.25, RD-3.26, RD-3.31

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Performing Provider	Unique Project	Project Option
Baylor University Medical Center	195018001.2.2	Expand Chronic Care Management Model – Diabetes (HbA1c poor control, BP control, foot exam)
Baylor Medical Center at Garland	121790303.2.2	
Baylor Medical Center at Irving	121776204.2.2	
Children's Medical Center	138910807.1.3	Pediatric disease registry – asthma
Denton County HHS	13660803.2.1	Implement disease registry – diabetes

[186] Cushman WC, Evans, GW, et al. Effects of intensive blood pressure control in type 2 diabetes mellitus. N Engl J Med. 2010. Apr 29; 362(17): 1575-85

[187] American Diabetes Association: http:www.diabetes.org

Methodist Charlton Medical Center	126679303.2.1	Expand Chronic Care Management Model – Diabetes (readmissions, Hba1c, BP control)
Methodist Dallas Medical Center	135032405.2.1	
Methodist Richardson Medical Center	209345201.2.1	
Parkland Health & Hospital System	127295703.1.3	Chronic care registry – Diabete, etc.
Parkland Health &Hospital System	127295703.2.4	Chronic Care Management Model – Diabetes
Texas Health Presbyterian Hospital Denton	020967801.2.2	Expand Chronic Care Management Model: Diabetes (HbA1c; 30 day readmissions)
Texas Health Presbyterian Hospital Kaufman	094140302.2.2	
UTSW – Faculty Practice Plan	126686802.2.2	Expand Chronic Care Management Model (Diabetes: HbA1c; All Cause Readmissions)

Plan for Learning Collaborative. We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. This model computes separate values for health care system, individual and community impacts.

Baylor Medical Center at Carrollton defined the population that will be directly impacted by the project as underserved patients who have Diabetes, Asthma, and/or CHF that are in need of education and treatment. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***3.*** We believe this project will increase the patient's ability to self-manage her illness(es) and maintain her health rather than relying on the physician or ED to manage her conditions. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***3.*** We believe, when a person is positively impacted, his propensity to understand his illness, share this knowledge with others and help spread health literacy increases. Patients learn to manage their illnesses and escalations themselves rather than relying on expensive resources such as the ED.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring

criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

195018001.2.1	***2.2.2***	***PROJECT COMPONENTS: NA***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton				***195018001***
Related Category 3 Outcome Measure(s):	*195018001.3.8* *195018001.3.9* *195018001.3.10*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%) (**Standalone measure**)* *Diabetes care: BP control (<140/80mm Hg) (**Standalone measure**)* *Diabetes care Foot exam- (**Non- standalone measure**)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-3]: Develop a comprehensive care management program Metric 1 [P-3.1]: Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and the Institute of Chronic Illness Care's Assessment Model may be utilized in program development. Baseline/Goal: Determine exact care model to be used for CHF, Diabetes and COPD/Asthma patients Data Source: Documentation of plan and report showing detailed plans for addressing chronic disease education program Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 109,335	**Milestone 2** [P-12]: Develop and implement plan for standing orders (i.e.: lab orders for chronic conditions) Metric 1 [P-12.1]: Documentation of plan for standing orders Data Source: Documentation of standing orders Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 59,639 **Milestone 3** [P-2]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disese care Metric 1 [P-2.1]: Increase percent of staff trained Baseline/Goal: Train 100% of clinic staff on Chronic Care Model Data Source: Documentation of in-service or signed proclamation of education Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 59,639		**Milestone 4** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric 1 [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period Goal: At least 80 unduplicated patients will be served by Chronic Care Management program over DY2 Data Source: E.H.R Metric 2 [I-21.4]: Improved compliance with recommended care regimens. Goal: 10% of patients in Chronic Care Management program (for at least 6 months) will have improved compliance with recommended regimens by the educators (non-physician regimens) Data Source: Patient survey, Educator Report /E.H.R	**Milestone 5** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric 1 [I-21.2] : Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: At least 176 unduplicated patients will be served by Chronic Care Management program over DY2 Data Source: E.H.R Metric 2 [I-21.4]: Improved compliance with recommended care regimens. Goal: 15% of patients in Chronic Care Management program (for at least 6 months) will have improved compliance with recommended regimens by the educators (non-physician regimens) Data Source: Patient survey, Educator Report/E.H.R

195018001.2.1	***2.2.2***	***PROJECT COMPONENTS: NA***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton				***195018001***
Related Category 3 Outcome Measure(s):	*195018001.3.8* *195018001.3.9* *195018001.3.10*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%) (**Standalone measure**)* *Diabetes care: BP control (<140/80mm Hg) (**Standalone measure**)* *Diabetes care Foot exam- (**Non- standalone measure**)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Milestone 4 Estimated Incentive Payment: $ 119,625	Milestone 5 Estimated Incentive Payment: $ 98,821
Year 2 Estimated Milestone Bundle Amount: $ 109,335	Year 3 Estimated Milestone Bundle Amount: $ 119,278		Year 4 Estimated Milestone Bundle Amount: $ 119,625	Year 5 Estimated Milestone Bundle Amount: $ 98,821
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 447,059				

Project Option 2.2.2 – Expand Chronic Care Management Model - Create Chronic Disease management and Prevention Program

RHP Project Identifier: 121790303.2.1
Performing Provider Name/TIP: Baylor Medical Center at Garland/121790303

Provider: Baylor Medical Center at Garland is a fully accredited, 240-bed medical center serving the residents of Garland, Texas, and the neighboring communities. Recognized for comprehensive services in heart and vascular care, diagnostic and interventional imaging, women's services, neonatal intensive care, sleep medicine, digestive disease, family medicine, and physical medicine and rehabilitation, Baylor Garland has 582 physicians on its medical staff representing a wide range of specialties. Baylor Garland's service area represents a population of 640,000.

Intervention(s): The project purpose is to provide focused education and point of care testing for underserved patients who have diabetes, CVD and/or Respiratory disease that are in need of education, clinical management and training within a primary care setting. We will co-locate primary care and chronic disease management services to improve clinical outcomes.

New v. existing initiative: This project is new because it will provide CHF and Asthma education and point of care testing, all which have not been done before. We have some diabetes education in our Clinics but not a formal focused program for the Medicaid/Uninsured patients.

Need for the project: One of the major identified by the Community Health Needs Assessment for Region 9 included Chronic Disease. Components of patient education and helping patients to understand their illness, how to better manage it, how to coordinate their lifestyle choices and offering point of care testing in order to achieve optimal health outcomes are essential in population management of chronic disease

Target population: Approximately 275,000 individuals in Dallas county have Diabetes. 19.6% of Dallas County has Asthma, which equates to 473,000 people. CHF accounts for about 200 deaths per 100,000 individuals in Dallas County. The underserved segment of this population is who we will target. We expect that this program's participants will be 85-90% Medicaid/Uninsured patients.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide chronic disease education and point of care testing for 671 patients in the Garland area.

Category 3 outcomes: Category 3 outcomes for this project were chosen because: 1) the ambulatory setting of the project and 2) historical trends of metrics that had material impact on patients in a 2-3 year time period.

- IT-1.10: Diabetes Care: HbA1c Poor Control. Our goal is to decrease the number of patients with uncontrolled HbA1cs (> 9.0%) from 12.7% currently to 11.5% in DY5 (or 1.2% improvement over baseline).

- IT-11.1: Diabetes Care: BP Control (< 140/80 mmHg). Our goal is to increase the number of diabetic patients in good BP control (< 140/80 mmHg) from 47.4% to 54.9% in DY5 (or 7.5% improvement over baseline).

- IT-1.13: Diabetes Care: Foot Exam. Our goal is to increase the number of diabetic patients who receive foot exams from 95.6% currently to 96.8% in DY5 (or 1.2% improvement over baseline)..

Project Description

The Baylor Clinic on the Baylor Medical Center at Garland campus, would house a carved out chronic disease management program to provide focused and dedicated education and care for patients (including Medicaid/Uninsured) with Diabetes, Cardiovascular Diseases (CVD) (i.e.: Congestive Heart Failure) and Respiratory Diseases (Asthma/Chronic Obstructive Pulmonary Disease) within a primary care setting. We expect that this program's participants will be 85-90% Medicaid/Uninsured patients .Specific staff, comprised of CHWs and Nurse Care Managers, would address the complex clinical and prevention needs of these patients and spend time specifically on management of these diseases. The focus of this time and education with patients would not only entail clinical counseling, but also include prevention components to focus on lifestyle issues and self-management. The other key advantage that patients will receive as part of this program is point of care testing for Diabetes (HbA1c testing and glucose testing using test strips) and Asthma (Peak Flow Meter Assessments). We believe this will overcome the barrier of patients' non-compliance with completing lab orders and any financial or transportation issues that would arise in obtaining these important lab results.

We plan to leverage the expertise and experience of both the Diabetes Health and Wellness Institute (Baylor entity in South Dallas) and Baylor Clinics to provide staff education, develop competencies, and create protocols that will result in a complete and robust program tailored for multiple community settings. The Diabetes Health and Wellness Institute would house this staff and appropriately triage and manage providers to see patient at Baylor Clinics based on volume and demand parameters. Baylor Clinics have had previous success in managing patients with chronic disease through the creation and development of a community health worker model (CHW). These successes/competencies will be leveraged to create programs around CVD and Respiratory illnesses.

Goals and Relationship to Regional Goals

The project goals for this program include: 1) increasing health literacy around chronic illnesses for patients in the community, 2) educate and teach self-management techniques for patients to manage their chronic diseases, 3) augmenting RN care managers with CHWs to serve a

greater number of patient through a carved out, focused care model, 4) increasing the number of patients who are screened and monitored for their chronic diseases using point of care testing and 5) increase education for patients with CHF and Asthma/COPD (2 disease states previously not offered). The purpose for a project in this area is to help identify patients with chronic diseases and provide them with treatment and education in a proactive fashion so that downstream complications can be avoided and ED/inpatient utilization can decrease.

One of the major identified by the Community Health Needs Assessment for Region 9 included Chronic Disease[188]. Components of patient education and helping patients to understand their illness, how to better manage it and how to coordinate their lifestyle choices to achieve optimal health outcomes are essential in population management of chronic disease. This project coincides with this need and focuses on education, lifestyle management, proactive counseling and decision making and clinical improvement. This leads to lower ED visits for acute issues related to chronic diseases and helps patients utilize costly services in the Region.

Challenges

Underserved patients experience multiple barriers to effectively manage their chronic illnesses. These include lack of knowledge, lack of social support, poor diets, insufficient physical activity, and limited access to care due to financial and transportation issues. By co-locating the chronic care management program within the primary care clinic, patients can receive medical care and chronic disease support at the same time. Additionally, the PCP's medical management is informed by the chronic care management team's interactions with the patient, which, in our experience, elicits new information regarding lifestyle and barriers to health. The RN/CHW model will be structured so that patient education is delivered in a format and context that is understandable and enjoyable for the patient. Lastly, the education and counseling will include lifestyle and self-management techniques so that this population can find ways to care for themselves that is relevant to their daily lives.

5-year Expected Outcome for Provider and Patients

Expected 5-year outcomes include: 1) at least 671 patients will have served by the Chronic Care Management model at the Baylor Clinic, 2) better clinical outcomes around HbA1c, foot exam completion and BP control, 3) more patients in the community will have had a point of care test completed for their diabetes or asthma which will provide real time results and opportunities for improvement, 4) increased literacy in the Garland community around chronic diseases and 5) decreased rates of avoidable/unnecessary complications (i.e. amputations) due to chronic diseases. We expect that this program's participants will be 85-90% Medicaid/Uninsured patients.

Starting Point/Baseline

Currently, the Baylor Clinic on the Baylor Medical Center at Garland offers a limited program focused on diabetes education. Of the patients enrolled in the program, approximately 13% of clinic patients have an HbA1c > 9.0. This baseline is not directly comparable to the proposed

[188] RHP 9 Community Health Needs Assessment

project for chronic care management because we will be including CHF and Asthma/COPD patients as well as part of the initiative. We estimated a target population based on the Community Health Needs Assessment, 11.4% of all Dallas County residents have diabetes, this equates to almost 275,000 individuals in the county. Literature shows that diabetes is more prevalent in the underserved community[189]. 19.6% of Dallas County has Asthma, which equates to 473,000 people. CHF accounts for about 200 deaths per 100,000 individuals in Dallas County. These statistics do not take into consideration any intersection of CHF, Asthma and Diabetes which makes individuals more complex and high risk. [190] Our project will serve approximately 671 new patients of this population.

Rationale

We selected this project option because of the prevalence of chronic disease in the underserved population. Through co-locating primary care, behavioral health and chronic disease management services, we can improve clinical outcomes. By increasing the availability of chronic care services and utilizing a team based approach, more patients can receive focused attention for their complex needs and learn to self-manage their illnesses in an effective way. We have demonstrated statistically significant reductions in mean HbA1c measures with a CHW model currently embedded in Baylor Clinics[191]. Thus expanding the educational services to serve more diabetes patients, and beginning to serve CHF and Asthma/COPD patients is a logical next step in improving the care of the population. The Community Health Needs Assessment identified the top 5 most prevalent conditions as: stroke, diabetes, CHF, failing kidneys and AMI. This project addresses 2 of these directly and 2 indirectly, it aligns exactly with the needs of the Region and the challenges that have been identified.[192]

Project Components

We will engage in continuous quality improvement activities throughout the project's duration such as: 1) identifying key challenges with the expansion of this project, 2) determine opportunities to scale all or part of the project- depending on available resources and financial constraints, 3) find ways to continuously integrate the chronic disease management program into the care team as much as possible.

Reasons for selecting outcome measures

The Chronic Care Management metrics and milestones we have chosen focus on finding the appropriate model that would be effective in Dallas County that also addresses multiple chronic illnesses. Based on the complexities of the underserved population, we structured our metrics to focus on increasing access, awareness and education for individuals in the region and in the latter years including metrics around increased compliance to recommended clinical protocols. We believe it will take time for patients to understand and epitomize good self-management

[189] RHP 9 Community Health Needs Assessment

[190] Healthy People North Texas: http://www.healthyntexas.org

[191] Walton, J, Snead, C. et.al. Reducing diabetes disparities through implementation of a community health worker led diabetes self-management education program. Journal of Family and Community Health. 2012: 35(2): 161-71.

[192] RHP 9 Community Health Needs Assessment

behaviors and it will also take times to see marked clinical outcome improvements. We do anticipate some clinical improvement for those patients that have been engaged in the chronic care management program for an extended period of time. We have not historically completed programs for CHF and Asthma/COPD and will use this opportunity to create a continuous improvement environment where these programs can be refined as we get more experience.

Unique community need identification number the project addresses: CN.8 Chronic Disease

How the Project significantly enhances an existing delivery system reform initiative

We currently do not receive any federal funding for chronic disease education and providing services for CHF and Asthma/COPD are new to the Baylor Clinic. This project coincides with the need to focus on chronic illnesses, as they are the main drivers of health care costs in the US. Diabetes alone costs the US almost $174 billion dollars a year. [193]

Related Category 3 Outcome Measures

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

Outcome Measure #1: IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (**Standalone measure**). In Dallas County, more than 11.4% of the population has a diagnosis of Diabetes with more than 32% of the population classified as obese and at risk for developing Diabetes[194]. Traditionally, the underserved population does not have access to the necessary medications, education and supplies to manage their diabetes, thus many times patients go undiagnosed or have poor glucose control. This project would facilitate timely and appropriate care for those with diabetes and ensure that regular labs and point of care testing is completed to monitor results and make appropriate interventions. We expect that at least 5-7% of patients that are seen regularly in a Baylor Clinic will have improved HbA1c levels Bodenheimer, et al., found that patient self-management of chronic disease conditions, such as diabetes, that was co-located in a primary care setting led to significant improvement in HbA1c control in patients[195]. A recent of edition of Managed Care found that patients with an HbA1c > 9 had on average almost $5000 worth of hospitalization costs, while those with an HbA1c of < 7 had about $2700 in hospitalization costs[196]. Focusing efforts on increasing improvement of good glycemic control will result diminishing in other co-morbid conditions and improve complication rates for these patients. We expect that at least 5-7% of patients that are seen regularly in a Baylor Clinic will have improved HbA1c levels.

[193] http://www.diabetes.org/diabetes-basics/diabetes-statistics/

[194] RHP 9 Community Health Needs Assessment

[195] Bodenheimer, T., Lorig, K.., Holman, H., Grumbach, K. Patient Self-management of Chronic Disease in Primary Care *JAMA* (May 15, 2008).

[196] MenzinJ, Korn, J, Cohen, J, et.al Relationship between glycemic control and diabetes related hospital costs in patients with type 1 or type 1 diabetes mellitus. J Manag Care Pharm. 2010; 16(4):264-275.

Outcome Measure #2: T-1.11 Diabetes care: BP control (<140/80mm Hg) – NQF 0061 (**Standalone measure**). At Baylor Health Care System, blood pressure control and management is a required part of the diabetes care in order to avoid other co-morbid conditions such as heart disease and stroke. A 2010 study in the New England Journal of Medicine by Cushman, et. al showed that better and less severe health outcomes related to cardiovascular episodes and stroke were achieved with tight blood pressure control in diabetic patients[197]. Events that would be fatal with higher blood pressure became nonfatal under better blood pressure control in these studies completed. As part of an outpatient, clinic based protocol, blood pressure control can be achieved in patients who will come to the Baylor Clinic. Again, similar to HbA1c, we expect modest improvement in BP in years DY4 andDY5 contingent upon patient participation in the clinic and chronic disease program. Our primary goal will be to have patients come in for basic services and chronic disease education.

Outcome Measure #3: IT-1.13 Diabetes care Foot exam- NQF 0056 (**Non- standalone measure**).An innovative part of this project is that the educators (CHWs and RN Care Managers) will be able to conduct diabetic foot exams as part of their education session with their patients. This will increase the rate of screening and allow these providers to identify issues such as ulcers and nerve issues earlier and more often. Foot exams are a low cost, highly effective way to avoid costly interventions such as wound care and management, amputations, neuropathy and other complex issues.. It is recommended by the American Diabetes Association that diabetic patients receive yearly foot exams to determine if there are predisposing factors for ulceration and amputation[198]. We expect this metric is one that we can easily achieve in DY4 and DY5 when the clinic is operational.

Relationship to other Projects

121790303.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
This chronic care management project is related because: 1) services will be co-located and 2) the chronic care team will be integrated with the primary care team to facilitate complete care and efficiency for the patient.

121790303.2.3- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment
The project involving developing care management functions to integrate primary and behavioral health needs of individuals is related to this project of chronic care management because often times patients have co-occurring chronic disease and mental health issues which require attention. These programs can cross-refer depending on the patient's needs.

Related Category 4 Population-focused improvements

[197] Cushman WC, Evans, GW, et al. Effects of intensive blood pressure control in type 2 diabetes mellitus. N Engl J Med. 2010. Apr 29; 362(17): 1575-85
[198] American Diabetes Association: http:www.diabetes.org

RD-1.1, RD-1.2, RD-1.4, RD-1.5, RD-2.1, RD-2.2, RD-2.4, RD-2.5, RD-2.7, RD-3.1, RD-3.2, RD-3.3, RD-3.4, RD-3.5, RD-3.6, RD-3.8, RD-3.10, RD-3.11, RD-3.12, RD-3.13, RD-3.14, RD-3.15, RD-3.24, RD-3.25, RD-3.26, RD-3.31

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Performing Provider	Unique Project	Project Option
Baylor University Medical Center	139485012.2.2	Expand Chronic Care Management Model – Diabetes (HbA1cl, BP control, foot exam)
Baylor Medical Center at Irving	121776204.2.2	
Trinity Medical Center (Baylor-Carrollton)	195018001.2.1	
Children's Medical Center	138910807.1.3	Implement pediatric disease registry – asthma
Denton County HHS	13660803.2.1	Implement disease registry – diabetes
Methodist Charlton Medical Center	126679303.2.1	Chronic Care Management Model – Diabetes
Methodist Dallas Medical Center	135032405.2.1	
Methodist Richardson Medical Center	209345201.2.1	
Parkland Health & Hospital System	127295703.1.3	Chronic care registry - Diabetes
Parkland Health &Hospital System	127295703.2.4	Chronic Care Management Model – Diabetes
Texas Health Presbyterian Hospital Denton	020967801.2.2	Chronic Care Management Model: Diabetes (HbA1c poor control, 30 day readmissions)
Texas Health Presbyterian Hospital Kaufman	094140302.2.2	
UTSW – Faculty Practice Plan	126686802.2.2	Chronic Care Management Model - Diabetes

Plan for Learning Collaborative:

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to CQI and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced projects and outcomes by computing the total value of Category 3 outcomes connected to each project. This model computes separate values for health care system, individual and the community impacts. ***Baylor Medical Center at Garland*** defined the population that will be directly impacted by the project as underserved patients who have Diabetes, Asthma, and/or CHF that are in need of education and treatment. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***3.*** We believe when a person is positively impacted, she increases her ability to self-manage her illness(es) and maintain her health rather than relying on the physician or ED to manage her conditions. To determine the value to the community, we concluded that, on a scale of 1 – 5, the value of this project is a ***3.*** We

believe, when patients understand their illness, they share knowledge with others and help spread health literacy increases. Patients learn to manage their illnesses and escalations themselves rather than relying on expensive resources such as the ED.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121790303.2.1	***2.2.2***	***PROJECT COMPONENTS: CQI***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Baylor Medical Center at Garland				***121790303***
Related Category 3 Outcome Measure(s):	*121790303.3.9* *121790303.3.10* *121790303.3.11*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%) (**Standalone measure**)* *Diabetes care: BP control (<140/80mm Hg) (**Standalone measure**)* *Diabetes care Foot exam- (**Non- standalone measure**)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Develop a comprehensive care management program Metric 1 [P-3.1]: Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and the Institute of Chronic Illness Care's Assessment Model may be utilized in program development. Baseline/Goal: Determine exact care model to be used for CHF, Diabetes and COPD/Asthma patients Data Source: Documentation of plan and report showing detailed plans for addressing chronic disease education program Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 199,124 **Milestone 2** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1 [P-9.1]: Increase the number of patients identified as	**Milestone 3** [P-2]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 [P-2.1]: Increase percent of staff trained Baseline/Goal: Train 100% of clinic staff on Chronic Care Model Data Source: Documentation of in-service or signed proclamation of education Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 144,822 **Milestone 4** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1 [P-9.1]: Increase the number of patients identified as needing screening test, preventative tests, or other clinical services Baseline/Goal: Compare patients with at least (1) or more chronic diseases from CHF, Diabetes,		**Milestone 6** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric 1 [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: At least 468 unduplicated patients will be served by Chronic Care Management program over DY2 Data Source: E.H.R Metric 2 [I-21.4]: Improved compliance with recommended care regimens. Goal: 15% of patients in Chronic Care Management program (for at least 6 months) will have improved compliance with recommended regimens by the educators (non-physician regimens) Data Source: Patient survey,	**Milestone 7** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. The following metrics are suggested for use with an innovative project option but are not required. Metric 1 [I-21.2] : Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: At least 671 unduplicated patients will be served by Chronic Care Management program over DY2 Data Source: E.H.R Metric 2 [I-21.4]: Improved compliance with recommended care regimens. Goal: 20% of patients in Chronic Care Management program (for at least 6 months) will have improved compliance with recommended

121790303.2.1	***2.2.2***	***PROJECT COMPONENTS: CQI***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Baylor Medical Center at Garland				***121790303***
Related Category 3 Outcome Measure(s):	*121790303.3.9* *121790303.3.10* *121790303.3.11*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%) (**Standalone measure**)* *Diabetes care: BP control (<140/80mm Hg) (**Standalone measure**)* *Diabetes care Foot exam- (**Non- standalone measure**)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
needing screening test, preventative tests, or other clinical services Baseline/Goal: Determine current baseline of Baylor Clinic patients with at least (1) or more chronic diseases from CHF, Diabetes, Asthma/COPD that have uncontrolled clinical metrics Data Source: E.H.R., Report documenting current patients in need of Chronic Care Management program Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 199,124		Asthma/COPD that have uncontrolled clinical metrics over DY2 to determine prevalence of these chronic diseases at the Baylor Clinic Data Source: E.H.R, Report documenting DY3 patient needs Milestone 4 Estimated Incentive Payment: $ 144,822 **Milestone 5** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. <u>Metric 1</u> [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: At least 250 unduplicated patients will be served by Chronic Care Management program over DY2 Data Source: E.H.R	Educator Report /E.H.R Milestone 6 Estimated Incentive Payment: $ 435,730	regimens by the educators (non-physician regimens) Data Source: Patient survey, Educator Report/E.H.R Milestone 7 Estimated Incentive Payment: $ 359,951

121790303.2.1	***2.2.2***	***PROJECT COMPONENTS: CQI***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Baylor Medical Center at Garland				***121790303***
Related Category 3 Outcome Measure(s):	*121790303.3.9* *121790303.3.10* *121790303.3.11*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%) (**Standalone measure**)* *Diabetes care: BP control (<140/80mm Hg) (**Standalone measure**)* *Diabetes care Foot exam- (**Non- standalone measure**)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Metric 2 [I-21.4]: Improved compliance with recommended care regimens. Goal: 10% of patients in Chronic Care Management program (for at least 6 months) will have improved compliance with recommended regimens by the educators (non-physician regimens) Data Source: Patient survey, Educator Report/E.H.R Milestone 5 Estimated Incentive Payment: $ 144,822			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $398,248	Year 3 Estimated Milestone Bundle Amount: $ 434,467		Year 4 Estimated Milestone Bundle Amount: $435,730	Year 5 Estimated Milestone Bundle Amount: $359,951
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,628,396				

Project Option 2.19.1 – Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals-Behavioral Health Counseling, Screening, Treatment

RHP Project Identifier: 121790303.2.2
Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Provider: Baylor Medical Center at Garland is a fully accredited, 240-bed medical center serving the residents of Garland, Texas, and the neighboring communities. Recognized for comprehensive services in heart and vascular care, diagnostic and interventional imaging, women's services, neonatal intensive care, sleep medicine, digestive disease, family medicine, and physical medicine and rehabilitation, Baylor Garland has 582 physicians on its medical staff representing a wide range of specialties. Baylor Garland's service area represents a population of 640,000.

Intervention(s): This project will co-locate and integrate outpatient behavioral health services using an LCSW to provide counseling services. Screenings for depression, substance abuse and anxiety will also be an integral part of the program. This is a new project that has not been done before. It will serve the BH needs of the Uninsured/Medicaid population.

Need for the project: The Community Needs Health Assessment identified behavioral and mental health issues as a large unmet need and also identified as the most difficult to access services in the Region. Behavioral Health issues are an identified impediment to clinical adherence and when addressed can create a material impact on clinical outcomes. Behavioral Health issues are especially prevalent in underserved populations.

Target population: Underserved (Medicaid and uninsured) population in the Garland area with behavioral health issues.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide screening and interventions to 671 patients in the Garland area. Approximately 85-90% of these patients will be Medicaid/Uninsured.

Category 3 outcomes: Category 3 outcomes for this project were chosen because: 1) the ambulatory setting of the project and 2) historical trends /literature based metrics that had material impact on patients in a 2-3 year time period.

- IT-11.1: Improvement in Clinical Indicator in Identified Disparity Group: Improvement in Diabetes Metrics (HbA1c, LDL, BP) for disparate group of uninsured/Medicaid patients with an underlying BH issue. Our goal is to have 5% of patients in DY3 achieve improvement in Diabetes Metrics (HbA1c, LDL BP), 10% in DY4 and 15% in DY5.
- IT-11.3: Improve utilization rates of clinical preventive services in target population with identified disparity: Improve utilization of BH services for patients who have been

screened/identifed and diagnosed with an underlying BH issue. Disparate population is underserved population with BH issue. Our goal is to increase the patients who engage in BH treatment rates from 10% in DY3 to 20% in DY5.

Project Description

This project will co-locate and integrate behavioral health services into the outpatient primary care setting. The model that we aim to develop would consist of providing a LCSW to provide basic counseling services to address behavioral health needs such as: anxiety, depression, and substance abuse issues. The screening tools we plan to use are evidence based and will most likely include: PHQ2 or 9, GAD-7 and alcohol and substance abuse screeners. Additionally, the LCSW would have the support of a Community Health Worker (CHW) to help with the screening and referral processes. The training for the CHWs , LCSWs and model development would occur at the Diabetes Health and Wellness Institute (Baylor entity in South Dallas) where the competencies and expertise would be created. From there, this staff can be triaged to clinics and community locations to provide behavioral health services. The behavioral health program would require that the LCSW and CHW to work together with the primary care team to: 1) identify the patients who have behavioral health issues, 2) coordinate the patient's care and appointments to fit both the behavioral health and primary care appointment in the same visit and 3) help the primary care team to identify those patients whose behavioral health issues are impeding the management of their acute/chronic disease management models. We anticipate that approximately 85-90% of patients will be Uninsured/Medicaid.

Goals and Relationship to Regional Goals

The goals of this project are to increase the baseline of behavioral health services provided and screenings conducted to the underserved population in Dallas County received in an outpatient setting. By co-locating the behavioral health service with a patient's PCMH, we anticipate that compliance and adherence to attending behavioral health appointments will increase. Through increased screening, awareness and intervention, we also anticipate that behavioral health issues such as anxiety, depression and substance abuse will be proactively identified and addressed in order to allow the clinician and patient to focus on more acute/chronic illnesses that require protocol adherence. The derivative goal of this would also be to decrease ED visits related to behavioral health issues that are manageable in the outpatient setting. We believe by treating the underlying barriers associated with behavioral health, this will result in better health outcomes for this population. The RHP 9 Community Needs Health Assessment identified behavioral and mental health issues are a large unmet need in most counties within the region and also identified as the most difficult to access services in the Region. There were three regional priorities around behavioral health including integrating behavioral health with primary care and addressing behavioral health in other settings. More than 10% o f Dallas County residents "binge drink" and there are more than 10 deaths per 100,000 related to suicide[199]. Only 19% of patients receive behavioral health and primary care services in the same

[199] Healthy People North Texas: http://www.healthyntexas.org

setting[200]. The most compelling statistic is that 100% of the 10 most frequently admitted patients had a co-occurring behavioral health diagnosis. The aforementioned statistics make a strong and significant case that basic behavioral health services can achieve "quick wins" for this underserved population. This project is directly aligned with the Regional needs and is positioned to help facilitate care related to substance abuse, anxiety and depression[201].

Challenges

The challenges with behavioral health initiatives are that identification of patients and willingness of those patients to participate in a formal program do not coincide. There is a stigma associated with receiving counseling or behavioral health services which makes it difficult for providers to identify patients that have these underlying behavioral health issues and even more difficult for providers to get patients to come in for these types of appointments. In the community, patients do not see their behavioral health issues as a medical condition, thus the problems are often ignored and results in these patients using the ED for their acute behavioral health escalations. While this program would not focus on serious psychiatric issues such as schizophrenia or bipolar disorders, identifying depression or anxiety can have a significant impact on the patient's propensity to comply with medication and clinical recommendations/protocols. The way we plan to address the challenges mentioned above is through providing these services in a non-threatening way by individuals (CHWs/LCSWs) that come from the community they are serving. By using CHWs or LCSWs over physicians or other higher level providers, this should put the patient at ease. The program will also be presented in a counseling type environment rather than a psychiatric evaluation environment. Lastly, we will make behavioral health screenings a routine part of most primary care visits so that the assessments coincide with the patient's typical care.

5-year Expected Outcome for Provider and Patients

The 5 year expected outcome is that at least 20% of the total unduplicated patients (approximately 671 patients) will receive behavioral health services at the Baylor Clinic at Garland. By identifying underlying behavioral health issues, acute and chronic medical issues can be addressed and compliance/adherence to clinical protocols should increase as well.

Starting Point/Baseline

There is no baseline for this project because there are no initiatives for behavioral health that are offered or ever have been at the Baylor Clinic located on the Baylor Medical Center at Garland. This is a brand new program that will be administered to Clinic patients. We do know that the target population in the Dallas county area is over 200,000 underserved individuals who suffer from a mental illness. We calculated this number taking the uninsured population in Dallas County (872,000)[202] and a 2011 statistic taken from the Centers for Disease Control and Prevention that found 23% of uninsured patients suffer from a mental illness.[203]

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[200] RHP 9 Community Health Needs Assessment
[201] Healthy People North Texas: http://www.healthyntexas.org
[202] http://quickfacts.census.gov/qfd/states/48/48439.html
[203] CDC: http://www.cdc.gov

Rationale

The reasons for selecting this project option are because behavioral health was not only identified as a major regional need, but Baylor Clinics have the infrastructure to effectively manage these types of issues within its PCMH framework. Many of our patients have underlying behavioral health issues which the physicians simply do not have time to address during a typical primary care visit, this model would allow patients to receive personalized attention for their behavioral health specific issues and allow the physicians to spend time on managing clinical issues. We believe by implementing a behavioral health component as part of the PCMH we have established, that patients will have improved overall health outcomes and providers will have greater satisfaction because these services will be performed by individuals who have expertise in managing behavioral health. Lastly, adding a behavioral health component to our primary care team will allow for cross communication between providers to understand all of the complex needs that are prevalent in this particular population.

Project Components

This behavioral health project has many components, all of which are addressed below:

a. Conduct data matching to identify individuals with co-occurring disorders who are:
   - not receiving routine primary care-*Patients who enter in to the behavioral health program will be automatically part of a PCMH*
   - not receiving specialty care according to professionally accepted practice guidelines: *We will track this metric as part of our specialty care project 1.9.2*
   - over-utilizing ER services based on analysis of comparative data on other populations: *This is a metric that we already track and will continue to do so*
   - over-utilizing crisis response services. *This particular factor may be difficult to gather data on and is not typically a data point we collect*
   - Becoming involved with the criminal justice system due to uncontrolled/unmanaged symptoms. *This factor may be difficult to gather data on-not typically collected*

b. Review chronic care management best practices such as Wagner's Chronic Care Model and select practices compatible with organizational readiness for adoption and implementation. *We plan to review the most effective models that address both chronic care and behavioral health to determine which model would easily address the intersection of both programs*

c. Identification of BH case managers and disease care managers to receive assignment of these individuals: We plan on hiring LCSWs and CHWs to act as BH care managers

d. Develop protocols for coordinating care; identify community resources and services available for supporting people with co-occurring disorders: As part of identifying which patients would be eligible and appropriate for this BH program, we will be developing clinical protocols to identify patients and coordinate care within the Baylor Clinic PCMH

e. Identify and implement specific disease management guidelines for high prevalence disorders. *We plan to address this criteria through our Chronic Care Management project (2.2.1- Expand Chronic Care Management Models)*
f. Train staff in protocols and guidelines. *All staff will be made aware of this program and be trained on scheduling and identifying patients who could be part of this BH program*
g. Develop registries to track client outcomes. *We currently have a robust EHR to track patient clinical metrics and measures, it would be redundant and inefficient to create a separate registry to track outcomes for this project. We will track outcomes in the current EHR*
h. Review the intervention(s) impact on quality of care and integration of care and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations. *As part of our monthly review of project status, this will be included as will review of the other DSRIP projects the Baylor Clinic will be engaged in. We will focus on the key challenges associated with expansion and determine how and if the BH needs to be scaled to meet patient needs.*

Reasons for Selecting Outcome Measures
The milestones and metrics chosen are focused on increasing volumes of patients seen. In order to be effective, patients will need to attend their appointments and be compliant with the recommended guidelines for behavioral health issues and subsequent medical issues. To achieve the proposed metrics and milestones all of the other DSRIP projects will have to coordinate and synchronize. This will be advantageous to the Region, as it will create synergy and a complete plan of care for the patients in the target population. In the Planning Protocol, there were no options for Improvement Milestones that were directly applicable to this Behavioral Health program. Many of the metrics were focused on chronic disease, which we have an entire separate DSRIP project dedicated to. Thus, we created two customizable improvement milestones that focus on 1) increasing patient volumes (capturing eligible patients) and 2) improving rates of screening for anxiety, depression and substance abuse.

Unique community need identification number the project addresses:

- CN.5- Behavioral Health
- CN.6-Behavioral Health and Primary Care

How the project significantly enhances an existing delivery system reform initiative
This project does not receive any federal funding and is a brand new initiative. There is currently no outpatient based behavioral health program offered to the underserved population at the Baylor Clinic at the Baylor Medical Center at Garland. This project will provide a low cost, effective intervention to those patients with behavioral health needs in a setting that is manageable for providers to identify potential escalation points.

Related Category 3 Outcome Measures

Category 3 metrics for this project were identified using literature only. Baylor has no previous experience with a behavioral health program of this nature. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting.

Outcome Measure #1: IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (**Standalone measure**). We plan to measure the impact of diabetes management and control for patients who have enrolled in the proposed behavioral health program. A recent study conducted in early 2012, by Jeffery Johnson, et al. showed a direct correlation between diabetes and depression. They cited that depression is the most common co-morbid condition present in 15-30% of patients with Type 2 diabetes and less than 50% are recognized as having depression[204]. Depression is associated with poorer self-care behaviors, decreased quality of life and substantially higher health care costs. Both diabetes and behavioral health issues are prevalent across the region, warranting measurement of the efficacy of a behavioral health program on chronic diseases.

Numerator: Number of patients with an improved Diabetes Percent of Opportunities Achieved (POA) improvement (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter

Denominator: Total number of patients with a Behavioral Health intervention/encounter

Our Baylor Clinics currently track the Diabetes Percent of Opportunities Achieved (POA) for all patients with Diabetes. This is calculated by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population. POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in diabetes management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their diabetic patients than in the prior reporting period.

For an illustrative example: For Diabetes- there are 3 opportunities (i.e. metrics) per patient (1) LDL < 100 (2) A1c < 8 and (3) BP < 130/80 mmHg. The denominator would be # of patients x 3. So, for example, if there are 10 patients x 3 opportunities each = 30 opportunities to be achieved. If, in the course of the year, only 20 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 20/30=67%. To achieve a 10% improvement in POA, we would have to have completed at least 23/30 opportunities to get at 76% achievement.

[204] Johnson, JA, Sayah, FA, et.al. Controlled trial of a collaborative primary care team model for patients with diabetes and depression: rationale and design for a comprehensive evaluation. BMC Health Services Research. 2012, 12:358

However, adding behavioral health as a subset of measurement for this patient population may change the actual improvement that is attainable. Because this is a new program, we do not have any historical data on the actual Diabetes improvement for those patients who receive a behavioral health intervention. We only have literature which has shown improvement in Diabetes with interventions related to depression. Thus, the improvement targets we have listed for Category 3 may differ as we implement the program.

Outcome Measure #2: IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (**Non-standalone measure**). We plan to focus on the treatment component of this metric, defining treatment as those patients who engage in the behavioral health program. We anticipate that patients who enter our Baylor Clinic and are identified as individuals who would benefit from a behavioral health intervention will have improved treatment and utilization rates.
Numerator: patients who are a Baylor Clinic patient and engage in behavioral health program
Denominator: patients who are a Baylor Clinic patient, eligible for behavioral health services
The idea of this metric is that by engaging patients in behavioral health treatment/interventions that their subsequent medical care will also improve. Patients who engage are those who have had at least two behavioral health interventions/encounters in the past 12 months. Patients eligible for behavioral health entail those that have 1) been identified through the PHQ2/9, GAD-7 and Substance Abuse screening tools that are in need of intervention, 2) self- identified need or 3) provider/clinician identification of patient need for behavioral health counseling. This Outcome Measure differs from our customized Improvement Milestone I-X: Target Population Reached: Increase Number of patients enrolled in BH program because the Improvement Milestone is focused on increasing volumes of eligible patients. Outcome measure 11.3 takes this one step further to ensure that the patient actually engages in the behavioral health program. By qualifying "engage" as a minimum of two interventions/encounters in the last 12 months, this varies from the Improvement Milestone of just increasing volume.

Relationship to other Projects

121790303.2.2- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program. The Chronic Care Management Model project is related because if patients have a co-occuring behavioral health issue and chronic diseases, the services are co-located and patients can be referred into both programs if necessary.

121790303.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion This behavioral health project is related to the expansion of primary care capacity project because 1) the services will be co-located and 2) the behavioral health team will be part of the overall primary care team; providing complete and efficient care for the patient.

Related Category 4 Population-focused improvements

RD-1.3, RD-1.7, RD-1.8, RD-1.1, RD-1.2, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.7, RD-3.36, RD-4.1, RD-4.2, RD-5

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives
Behavioral Health is pressing issue across the Region and will require collaboration and coordination between providers to manage these types of issues in a less costly, personalized setting. There are several other projects submitted by performing providers related to improving behavioral health services.

Plan for Learning Collaborative. We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly CQI and will advance the success of this project.

Project Valuation
Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced our projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. That model computes separate values for health care system, individual and community impacts.

Baylor Medical Center at Garland defined the population that will be directly impacted by the project as the underserved PCMH Baylor Clinic patients with an underlying behavioral health issue(s). We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***3.*** We believe a person will increase compliance and adherence to clinical protocols and when their satisfaction increases so will self-management of their illnesses. To determine the value to the community, we concluded that, on a scale of 1 – 5, the value of this project is a ***4.*** We believe, when a person is positively impacted, their productivity in the community increases as mentioned in the Community Health Needs Assessment 25% of the population reported lost work days due to a mental health issue. In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative

score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121790303.2.2	*2.19.1*	*2.19.1.(A-H)*	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS-*** *BEHAVIORAL HEALTH COUNSELING, SCREENING AND TREATMENT*	
Baylor Medical Center at Garland				*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.12* *121790303.3.13*	*3.IT-11.1* *3.IT-11.3*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider – Diabetes Improvement (**Standalone measure**)* *-Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity- BH Treatment Rate Improvement (**Non-standalone measure**)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Data matching is performed identifying service utilization patterns of people with co-occurring disorders and analysis conducted to identify over and under-utilization patterns. Metric 1 [P-4.1]: Data analysis report produced. Baseline/Goal: Determine number of patients with dual diagnosis- either self- identified or through previous medical history- to understand actual need in community Data Source: E.H.R/patient survey Milestone 1 Estimated Incentive Payment: $ 126,622 **Milestone 2** [P-5]: BH case managers and disease care managers are identified. Metric 1 [P-5.1]: Number of staff identified with the capacity to support the targeted population. Baseline/Goal: Revamp/modify roles of existing staff to take on	**Milestone 4 [P-4]**: Data matching is performed identifying service utilization patterns of people with co-occurring disorders and analysis conducted to identify over and under- utilization patterns. Metric 1 [P-4.1]: Data analysis report produced. Baseline/Goal: Determine number of current patients that have a dual diagnosis and compare to DY 2 data collected Data Source: E.H.R/patient survey Milestone 4 Estimated Incentive Payment: $103,604 **Milestone 5** [P-6]: Care coordination protocols are developed. Metric 1 [P-6.1]: Written protocols are easily available to staff. Baseline/Goal: Educate 100% of clinic staff on BH protocols/standing order Data Source: Documentation of completed education Milestone 5 Estimated Incentive Payment:	**Milestone 8** [I-X]: Patient enrollment in program Metric 1 [I-X.1]: Target Population Reached: Increase Number of patients enrolled in BH program Goal: 468 unduplicated patients will be identified and seen for a BH issue over DY2 Data Source: E.H.R Milestone 8 Estimated Incentive Payment: $207,810 **Milestone 9** [I-X]: Improve screening rates for depression, anxiety and substance abuse Metric 1 [I-X.1]: Short Term Outcomes: Improve % of patients screened with at least one BH tool Goal: 20% of all patients will be screened with PHQ2/9 or GAD-7 or Substance Abuse screening Data Source: E.H.R (% is the same to account for attrition in patient population) Milestone 9 Estimated Incentive	**Milestone 10** [I-X]: Patient enrollment in program Metric 1 [I-X.1]: Target Population Reached: Increase Number of patients enrolled in BH program Goal:671 unduplicated patients will be identified and seen for a BH issue over DY2 Data Source: E.H.R Milestone 10 Estimated Incentive Payment: $171,669 **Milestone 11 [**[I-X]: Improve screening rates for depression, anxiety and substance abuse Metric 1 [I-X.1]: Short Term Outcomes: Improve % of patients screened with at least one BH tool Goal: 25% of all patients will be screened with PHQ2/9 or GAD-7 or Substance Abuse screening Data Source: E.H.R (% is the same to account for attrition in patient population) Milestone 11 Estimated Incentive

121790303.2.2	*2.19.1*	*2.19.1.(A-H)*	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS-*** *BEHAVIORAL HEALTH COUNSELING, SCREENING AND TREATMENT*	
			Baylor Medical Center at Garland	*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.12* *121790303.3.13*	*3.IT-11.1* *3.IT-11.3*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider – Diabetes Improvement (**Standalone measure**)* *-Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity- BH Treatment Rate Improvement (**Non-standalone measure**)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
BH patients and caseloads Data Source: Documentation of trained staff and role descriptions Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 126,622 **Milestone 3** [P-6]: Care coordination protocols are developed. Metric 1 [P-6.1]: Written protocols are easily available to staff. Baseline/Goal: Develop protocols for identifying BH patients and protocols for making appointments. Ensure that executive physician committee signs off on protocols for LCSW. Data Source: Documentation of clinical protocols and processes Milestone 3 Estimated Incentive Payment *(maximum amount):* $126,622	$103,604 **Milestone 6** [I-X]: Patient enrollment in program Metric 1 [I-X.1]: Target Population Reached: Increase Number of patients enrolled in BH program Goal: 250 unduplicated patients will be identified and seen for a BH issue over DY2 Data Source: E.H.R Milestone 6 Estimated Incentive Payment: $103,604 **Milestone 7** [I-X]: Improve screening rates for depression, anxiety and substance abuse Metric 1 [I-X.1]: Short Term Outcomes: Improve % of patients screened with at least one BH tool Goal: 15% of all clinic patients will be screened with PHQ2/9 or GAD-7 or Substance Abuse screening Data Source: E.H.R Milestone 7 Estimated Incentive Payment:	Payment: $207,810	Payment: $171,669

121790303.2.2	***2.19.1***	***2.19.1.(A-H)***	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS-*** *BEHAVIORAL HEALTH COUNSELING, SCREENING AND TREATMENT*
Baylor Medical Center at Garland			*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.12* *121790303.3.13*	*3.IT-11.1* *3.IT-11.3*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider – Diabetes Improvement (**Standalone measure**)* *-Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity- BH Treatment Rate Improvement (**Non-standalone measure**)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	$103,604		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $379,867	Year 3 Estimated Milestone Bundle Amount: $ 414,415	Year 4 Estimated Milestone Bundle Amount: $415,619	Year 5 Estimated Milestone Bundle Amount: $343,338
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 1,553,239			

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program – Care Connect

RHP Project Identifier: 121790303.2.3
Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Provider: Baylor Medical Center at Garland is a fully accredited, 240-bed medical center serving the residents of Garland, Texas, and the neighboring communities. Recognized for comprehensive services in heart and vascular care, diagnostic and interventional imaging, women's services, neonatal intensive care, sleep medicine, digestive disease, family medicine, and physical medicine and rehabilitation, Baylor Garland has 582 physicians on its medical staff representing a wide range of specialties. Baylor Garland's service area represents a population of 640,000.

Intervention(s): This project will identify and connect underserved patients in the hospital to a PCP/PCMH, create a multi-disciplinary care plan for frequently admitted patients and provide comprehensive follow up calls to patients to ensure they have an appointment and transportation to get to it. This project would be an expansion of Care Connect at Baylor Garland. We will be adding additional staff to serve more Medicaid/Uninsured patients add coverage on nights and weekends and create Care Plans for high risk patients.

Need for the project: Connecting patients to a PCP/PCMH will reduce ED utilization and provide outpatient services for complex patients. Over-utilization of the ED was identified as a Regional issue.

Target population: The 872,000 uninsured and Medicaid population in Dallas County without a PCP/PCMH who come to the ED. Approximately 85% of new patients seen in this program will be Medicaid/Uninsured.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide access to an anticipated 3600 new patients from the community.

Category 3 outcomes: Category 3 outcomes for this project are from 2 different domains the true impact of this project is through ED appropriate utilization and cost savings. Both are priorities for the Region, which is why we felt we should show improvement in both areas.

- IT-5.1: Improved Cost Savings. Our goal is to increase cost savings of healthcare utilization (total cost of care in one year) of patients who have been connected to a PCP/PCMH appointment from 15% in DY3 to 25% in DY5. .
- IT-9.2: ED Appropriate Utilization. Our goal is to decrease all ED visits (including ACSC) from 25% in DY3 to 35% in DY5 and targeted conditions ED utilization (CHF, Diabetes, ESRD, CVD/Hypertension, BH/SA, COPD, Asthma) from 10% in DY3 to 20% in DY5. We will be excluding pediatric emergency visits as part of this metric measurement because

Baylor Medical Center at Garland does not see a large volume of pediatric patients in the ED.

Project Description

This project aims to create a fluid care navigation program located at Baylor Medical Center at Garland Emergency Department for patients (including Medicaid/Uninsured) who are identified (or proclaim) to not have a primary care physician and/or patient centered medical home to address their post-acute care needs. Approximately 85% of new patients enrolled in this program will be Medicaid/Uninsured. By having staff physically located in these locations, patients can receive real time assistance in finding a provider and ensuring they are connected with the appropriate resources they would require once discharged home. We will include staff coverage on the weekends as well to ensure that patients are able to be seen and connected to resources 7 days/week. Additionally, in order to close the loop, staff will follow-up with patients to make sure they have an appointment and that they attend their appointment. The staff will also be responsible for ensuring that other barriers such as transportation are addressed and patients are able to attend their follow-up visits. The Care Connect staff will receive e-mail notifications any time a patient revisits the hospital, at this time staff will proactively visit with the patient to ensure the patient is able to access their PCP/PCMH appointment and/or recommended community resource(s). Care plans will be developed for patients with high hospital utilization (especially patients with frequent emergency department visits) and complex needs. Care plans will include involvement with Social Work Supervisor, Hospital Medical Director and other hospital staff. Patients with care plans will be contacted as often as needed to ensure continuity of the care plan.

Goals and Relationship to Regional Goals

The goals for this project are: 1) to connect a greater number of patients to a PCP/PCMH in the Garland community, 2) ensure the patients have the resources they need to care for themselves post discharge, 3) keep patients out of the ED and 4) create a care plan for high risk patients which ensures that the patient is receiving the follow-up care they need and are identified by staff when they readmit to the hospital.

One of the major goals for the region is to reduce ED utilization and readmissions. This project focuses on and emphasizes both of these components. The entire impetus of the project is focused on Care Coordination and ensuring that patients are triaged to appropriate community and outpatient based resources. This is a strategy to decrease overall spending on health care in the region and help more patients connect to the essential primary care needed to maintain their health.

Challenges

Challenges with the underserved population almost always route back to the lack of continuity of care across the continuum. Because of their financial, time and resource constraints, this population often find a temporary fix to their health issue and once discharged from the hospital do not receive the care they need to stay healthy. If a patient is given an appointment

post discharge, they may have issues with transportation and other barriers that impede their access to care. Typically there is no follow-up to ensure the patient knows when their appointment is and if they actually went. This program aims to address these issues by identifying patients who do not have a PCP/PCMH, finding one for them, ensuring they have the resources they need to keep their appointment and then following up with the patient.

5-year Expected Outcome for Provider and Patients

The 5-year expected outcomes for this project include: 1) a minimum of 3600 patients connected to a PCP, PCMH or community resource, 2) 35% of these patients will have confirmed appointments within 14 days post-discharge. We expect that there will be fewer ED visits and readmissions for this population that was connected through this program and will experience overall improved health outcomes due to receiving appropriate and adequate post-acute care.

Starting Point/Baseline

The baseline for this project at Baylor Medical Center at Garland is 849 patients served by the program from November 2011 to July 2012 . This program is still relatively new at Baylor Medical Center at Garland. The purpose of this project is to expand the scope and coverage of this project for more patients. We anticipate that the targeted population for the entire region is approximately 260,000 patients. This is calculated by taking the average rate of patients who are uninsured that do not have a PCMH/PCP (30%) multiplied by the total number of uninsured in Dallas (36% of the population).[205]

Rationale

We selected this project because it is a low cost, highly effective way to help promote the continuity of care for the underserved population. Utilizing CHWs and social work as the main staff involved in this project, these individuals are connected to the community and understand patients' complex needs. This project helps patients that do not have a PCP/PCMH connect to one and then also offers the continuous improvement piece that is often missing in these types of initiatives. We selected this project for Baylor Medical Center at Garland because we have seen demonstrated results in the time the project has been implemented at Baylor Garland. The program has reduced readmissions and lowered ED utilization. The other attractive component this project are the multidisciplinary care plans that will be developed for the highest risk patients to identify these individuals and hone in on triggers that cause them to (re)admit. We believe that this intervention is an effective way for staff to be involved with the patient at a grassroots level and allow patients to feel that they have someone responsible for their ongoing care and navigation needs.

Project Components

This project has multiple components from the protocol, all of which are listed and addressed below:

[205] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/48439.html

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency: *This is a core part of our program, we will be focusing on all ED patients that are identified to not have a PCP/PCMH. Our Care Plans are developed for patients who are frequent ED utilizers as well. Lastly, our CHWs that we will be hiring come directly from the communities they serve so they understand the challenges/issues with the patients that come from that community.*

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators. *This project will primarily be using CHWs and Social Workers to help navigate the patients and manage their care.*

c) Connect patients to primary and preventive care. *The impetus of this program is focused on connecting patients to PCP/PCMH*

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management. *Through connecting patients to a Baylor Clinic PCMH, these services for chronic care management will also be addressed.*

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. *This project will be part of an overall Baylor initiative that will be analyzing and evaluating the progress and challenges/barriers for all DSRIP projects. We will focus on identifying key challenges associated with the expansion and opportunities to scale the project where appropriate.*

Reasons for selecting outcome measures

The milestones and metrics that we chose are directly related to two of the goals identified by the region: 1) need for more care coordination and 2) overuse of ED services. The metrics we have in place increase the number of the target population served over the Waiver period and emphasize the connection rate to a PCP/PCMH. In addition, we have added a metric that creates regular reports that show comparative analyses year over year of the program. We believe by running detailed reports on what services were provided and how these coincide with the needs of the community, will allow for maximum effectiveness and positive outcomes of the project. These metrics directly impact the health and well-being of the patients served and insure continuity in their care.

Unique community need identification number the project addresses: CN.12- ED Usage and Readmissions

How the project significantly enhances an existing delivery system reform initiative

This project does not receive any federal funds and is a new initiative. It is focused on reducing high cost ED utilization and connects patients with a PCP/PCMH to avoid subsequent ED visits. This is a low cost, highly effective way to keep patients in appropriate care settings.

Related Category 3 Outcome Measures

The Standalone and Non-standalone metrics come from 2 different domains because the true impact of this project is through ED appropriate utilization and cost savings. Both are priorities for the Region, which is why we felt we should show improvement in both areas.

Outcome Measure #1: IT-9.2 ED appropriate utilization (**Standalone measure**). According to the Community Health Needs Assessment of Region 9, 68% of the ED visits in the region were for non-emergent situations that could have been handled in the primary care/outpatient settings. This metric is at the heart of the care navigation project we are proposing and will have a direct impact on patients in Dallas County utilizing the ED at a decreased rate. This project uses the popular concept created by Dr. Atul Gawande, referred to as "hot spotting" indicating a focus on finding the high risk/high utilization rates of the ED and determining the root cause for these visits, and then working to remedy those issues. Issues such as transportation, navigation of community and appropriate resources are just two examples that can lead to more effective use of the ED[206].

Outcome Measure #2: IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (**Non- standalone measure).** Financial constraints are a main concern for the Region in being able to provide high quality care to the underserved population. Cost savings and effectiveness are a key part of the overall Waiver and require providers to be good stewards of their resources. This metric is appropriate because it emphasizes appropriate utilization of resources and reinforces the concept of cost effectiveness. We plan to measure the cost effectiveness and cost utilization of this project. According to the Texas Medical Association, the cost of treating a condition that could be treated in the doctor's office for $56.21 (including lab and x-ray) costs $193.92 in the Emergency room[207]. This cost differential multiplied by the 443,000 uninsured in Dallas County creates a significant cost to the county and Region. On a more global level, AHRQ found that the average cost in 2006 for an uninsured patient stay in the hospital cost about $19,400. There is definite room for opportunity to produce cost savings for this target population[208].

Relationship to other Projects

121790303.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

The navigation program is located in the hospital and will facilitate the connection of patients to the Baylor Clinic that are identified by the staff to not have a PCP/PCMH.

Related Category 4 Population-focused improvements

This project will help to support, reinforce and enable Category 4 population focused improvements through project design and appropriate intervention for targeted populations:

[206] Gawande, A. The hot spotters: can we lower medical costs by giving the neediest patients better care? The New Yorker. (2011).
[207] Texas Medical Association: http://www.texmed.org
[208] AHRQ: http://www.ahrq.gov

The thought here is that if patients that are identified in the ED setting to not have a PCP/PCMH or other adequate resources, that once connected they will have lower utilization of the hospital. This project does not necessarily improve conditions while patients are in the hospital. RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.7, RD-1.8, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7, RD-4.1, RD-4.2, RD-5.1

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Care Coordination models require an initial connection but also require resources to triage patients to. Once a patient is identified to need a PCP/PCMH or another community resource, it becomes the Region's responsibility to ensure there are outlets for these patients to receive the care they need. Care Navigation programs serve the patients located in the specific EDs/inpatient units of the performing providers and thus do not duplicate patients on a per visit basis. While our geographies overlap, these programs are localized to individual hospitals. There are 12 RHP 9 projects related to patient navigation (including Baylor's projects). The projects are as follows:

Performing Provider	Unique Project
Baylor Medical Center at Irving	121776204.2.3
Baylor University Medical Center	139485012.2.3
Children's Medical Center	138910807.2.3
Medical Center of Lewisville (HCA)	094192402.2.3
Methodist Charlton Medical Center	126679303.2.2
Methodist Dallas Medical Center	135032405.2.1
Methodist Richardson Medical Center	209345201.2.1
Parkland Health & Hospital System	127295703.2.7
Texas Health Presbyterian – Denton	020967801.2.1
Texas Health Presbyterian – Kaufman	094140302.2.1
University of Texas Southwestern – Faculty	126686802.2.4
Univeristy of Texas Southwestern – Hospital	175287501.2.1

Plan for Learning Collaborative.

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 3 Regional Healthcare Partnerships. In order to be consistent in our valuation methodology, we have used the same process and technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we

have priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. This methodology is consistent with our approach in our other RHPs. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor Medical Center at Garland defined the population that will be directly impacted by the project as ***underserved individuals in the Garland and Dallas County area*** that access to specialty care services. People who receive these services must be a patient of the Baylor Clinic prior to being referred to specialty care. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3We believe this to be the correct number because, when a person is positively impacted, their ability to maintain their health and address their complex health needs will be addressed. People will receive the procedures, diagnostics, etc. that they previously were unable to afford or could not have access to. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***3 .***We believe this to be the correct number because, when a person is positively impacted, their clinical exacerbations are lessened and they incur less costly procedures and surgeries versus waiting for specialty care and having a more serious condition occur.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121790303.2.3	***2.9.1***	***2.9.1.(A-E)***	***ESTABLISH/EXPAND A CARE NAVIGATION PROGRAM-*** *CARE CONNECT*	
Baylor Medical Center at Garland				*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.14* *121790303.3.15*	*3.IT-5.1* *3.IT-9.2*	*Improved cost savings: Demonstrate cost savings in care delivery* ***(Non-Standalone)*** *ED appropriate utilization (****Standalone measure****)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: 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: Hire staff - 1 FTE Data Source: Documentation of employment Metric 2 [P-2.2]: Number of unique patients enrolled in the patient navigation program; Baseline/Goal: Establish baseline of patients seen in DY2 Data Source: E.H.R./Navigation database Metric 3 [P-2.3]: Frequency of contact with care navigators for high risk		**Milestone 3** [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. Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided Baseline/Goal: Provide completed report to compare types of navigation offered in DY2 v. DY3 Data Source: E.H.R/Navigation notes and database Milestone 3 Estimated Incentive Payment: $ 205,537 **Milestone 4** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric 1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care referrals	**Milestone 5** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric 1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care referrals to at least 40% of patients identified by care navigation program Data Source: E.H.R./Patient Navigation program database Metric 2 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Identify at least 1200 patients Data Source: E.H.R./Patient Navigation program database	**Milestone 6** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care referrals to at least 50% of patients identified by care navigation program Data Source: E.H.R./Patient Navigation program database Metric 2 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Identify at least 1440 patients Data Source: E.H.R./Patient Navigation program database Milestone 6 Estimated Incentive Payment: $ 340,569

121790303.2.3	***2.9.1***	***2.9.1.(A-E)***	***ESTABLISH/EXPAND A CARE NAVIGATION PROGRAM-*** *CARE CONNECT*	
Baylor Medical Center at Garland				*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.14* *121790303.3.15*	*3.IT-5.1* *3.IT-9.2*	*Improved cost savings: Demonstrate cost savings in care delivery* ***(Non-Standalone)*** *ED appropriate utilization (****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)**
patients. Baseline/Goal: Track frequency of patient contact with navigator while in ED setting Data Source: E.H.R./Patient Navigation program database Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 188,402 **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. <u>Metric 1</u> [P-5.1]: Collect/report on types of patient navigator services provided Baseline/Goal: Create report format and educate navigators about data points to be collected Data Source: Documentation of report Milestone 2 Estimated Incentive Payment *(maximum amount):*	to at least 30% of patients identified by the navigation program Data Source: E.H.R./Patient Navigation program database <u>Metric 2</u> [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Identify at least 960 patients Data Source: E.H.R./Patient Navigation program database Milestone 4 Estimated Incentive Payment: $ 205,537	Milestone 5 Estimated Incentive Payment: $ 412,268	

121790303.2.3	***2.9.1***	***2.9.1.(A-E)***	***ESTABLISH/EXPAND A CARE NAVIGATION PROGRAM-*** *CARE CONNECT*	
Baylor Medical Center at Garland				*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.14* *121790303.3.15*	*3.IT-5.1* *3.IT-9.2*	*Improved cost savings: Demonstrate cost savings in care delivery* ***(Non-Standalone)*** *ED appropriate utilization (****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)**
$ 188,402			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 376,804	Year 3 Estimated Milestone Bundle Amount: $ 411,073	Year 4 Estimated Milestone Bundle Amount: $ 412,268	Year 5 Estimated Milestone Bundle Amount: $ 340,569
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 1,540,714			

Project Option 2.12.2 – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)

RHP Project Identifier: 121790303.2.4 – Pass 2
Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Provider: Baylor Medical Center at Garland is a fully accredited, 240-bed medical center serving the residents of Garland, Texas, and the neighboring communities. Recognized for comprehensive services in heart and vascular care, diagnostic and interventional imaging, women's services, neonatal intensive care, sleep medicine, digestive disease, family medicine, and physical medicine and rehabilitation, Baylor Garland has 582 physicians on its medical staff representing a wide range of specialties. Baylor Garland's service area represents a population of 640,000.

Intervention(s): This project will provide in-home visits to the highest risk uninsured and Medicaid patients. Risk is defined by patient propensity of complications, (re)admissions, downstream healthcare utilization and costs within the parameters of socioeconomic and clinical risk indicators. The team will be led by an APRN overseen by a Medical Director and augmented with a Social Worker, LVN and Care Coordinator who will have overall oversight and responsibility of continuity of care for the patients in the program. Services such as examinations and clinical decision making to changing urinary catheters, labs, vaccinations and medication reconciliation, management and education will be available in the patient's home. This project is a new initiative at Baylor Medical Center at Garland.

Need for the project: High risk and complex patients that need intensive management will receive care in their homes to address acute and chronic needs. This should facilitate fewer visits to the ED, greater compliance to clinical protocols and regimens and create improved quality outcomes.

Target population: The top 5% highest risk patients of the 872,000 uninsured and Medicaid population in Dallas County that have at least one of the following characteristics: homebound, disabled, multiple chronic diseases, polypharmacy or any other medical or social conditions limiting the patients' ability to access care in an ambulatory care setting.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide care to 50 high risk patients.

Category 3 outcomes: Category 3 outcomes for this project focus on identifying and improving impediments to patient care in order to increase compliance and better outcomes.

- IT-10.1: Quality of Life. Our goal is to increase the mean score (from time of enrollment to current survey) on QOL assessments by 7% by DY5 for patients in the program for at least 6 months.

- IT-10.2: Activities of Daily Living. Our goal is to increase the mean score (from time of enrollment to current survey) on ADL assessments by 7% by DY5 for patients in the program for at least 6 months.

Project Description

The Vulnerable Patient Network (VPN) program provides home visits to the highest risk (clinically, economically and socially) and vulnerable Medicaid and uninsured patients. Using a combination of the Hot Spotting model developed by Dr. Jeffery Brenner of the Camden Coalition of Healthcare Providers[209] and a validated risk stratification tool, we will stratify and identify the top 5% of high risk patients in the Medicaid and Uninsured population. Qualifiers for enrollment in this program include patient characteristics that include but are not limited to: homebound, disabled, multiple chronic diseases, polypharmacy or any other medical or social conditions limiting the patients' ability to access care in an ambulatory care setting. A multidisciplinary team comprised of an advanced nurse practitioner (APRN) and LVN to see patients in the home and provide acute, primary and chronic care. In addition, social workers will be part of the team to address barriers to care and any social issues. Care Coordinators will also be part of this team to facilitate coordination and continuity of care for patients and have high level oversight for patients; bringing together the necessary components of care for these complex patients. Lastly, a Medical Director will have management over the entire project. A full spectrum of services will be available in the patient home ranging from examinations and clinical decision making to changing urinary catheters, labs, vaccinations and medication reconciliation, management and education.

Goals and Relationship to Regional Goals

The goals for this project are: 1) Increase patients who receive primary care, 2) Overcome access issues for high risk patients, 3) Address acute care issues in the patient's home rather than the Emergency Department, 4) Increase patient compliance and adherence to regimens, 5) Decrease barriers to care around receiving medications and overall care, 6) Increase contact rate with provider for high risk patients and 7) Increase medication reconciliation frequency.

Two of the goals for the region include increasing healthcare capacity and decreasing ED utilization and readmissions. This project increases access to care for those high risk patients who are unable or unwilling to be seen in primary care office. It creates additional points of care for patients to receive care and improve compliance and clinical outcomes. Patients who have multiple chronic diseases and unable to go to appointments can have their conditions proactively managed in their homes. Together long term disease management and avoidance

[209] Gawande, A. "The hot spotters." *The New Yorker*, January 24, 2011.

of exacerbations lead to better clinical outcomes, lower ED utilization, lower costs and better overall patient health. According to the Community Needs Assessment, the conditions with the highest ED visit volumes for the Medicaid and uninsured population were: diabetes, CHF and stroke. With proper and consistent management, these conditions are manageable.[210] The top 10 utilizers of health care services in the region accumulated $26 million in costs.[211] These patients would be candidates for this Home Visit program, identifying them through the "hot spotting" methodology[212] and proactively managing their conditions. This program will help to improve outcomes of chronic diseases and related complications by proactively managing the patient in a setting that is convenient and comfortable for them, hopefully increasing compliance to treatment protocols and medication adherence.

Challenges

High risk (clinical and socioeconomic) uninsured and underinsured patients often have multiple co-morbidities, issues with access and lack of resources to care for themselves. These patients, due to financial and other constraints cannot afford medications, transportation to appointments and may be physically incapable of leaving their homes to receive care. These are the patients that end up having their clinical conditions escalate and end up in the Emergency Department because the lack of adequate and timely primary care. This program would remove barriers to access by providing a full range of clinical and social services high risk patients need in their homes. This also allows the care team to physically survey the patient's living conditions and find inhibitors to help the patient overcome these issues to better care of themselves.

5-year Expected Outcome for Provider and Patients

The 5-year expected outcomes for this project include: 1) provide home care to a minimum of 50 patients, 2) improve mean quality of life scores by a 7% over baseline for patients enrolled in VPN for at least 6 months, 3) improve Activities of Daily Living mean scores by 7% over baseline for patient enrolled in VPN for at least 6 months and create a robust, multidisciplinary care team that manages everything for the patient from scheduling appointments, receiving labs/medications to addressing social issues and helping the patient to overcome barriers to care. We expect that ED and inpatient utilization will decrease and this cohort of high risk patients will have improved clinical outcomes and fewer downstream disease complications/issues.

Starting Point/Baseline

The baseline for this project at Baylor Medical Center at Garland does not exist. The program at Baylor University Medical Center has not been rigorously tracked. Approximately 90 patients have been seen over the past 2 years. On average, patients remain in the program for 298 days. Currently, the patient panel for the program includes Medicare patients who, under this project will be transitioned to a different service. Although this project is an extension of the current program Baylor Medical Center at Garland has in place, it has many new components

[210] RHP 9 Community Health Needs Assessment

[211] RHP 9 Community Health Needs Assessment.

[212] Gawande, A. "The hot spotters." *The New Yorker*, January 24, 2011

(expanded care team, more services, greater frequency of visits, focus on Medicaid and Uninsured, etc).

Rationale

We selected this project because in the populations we serve, many times patients are unable or unwilling to come to the Baylor Clinic to receive the care they need. The Medicaid and uninsured populations have multiple social, economic and other barriers on top of clinical issues that prevent them from appropriately managing their health. This project uses a face to face mechanism whereby patients are monitored regularly and have all of their needs met in a venue that is convenient and comfortable for them. In a recent article in Health Affairs, entitled Six Features of Medicare coordinated care demonstration programs that cut hospital admissions of high risk patients, Brown found supplementing telephone calls to patients with frequent in-person meetings; occasionally meeting in person with providers; acting as a communications hub for providers; delivering evidence-based education to patients; providing strong medication management; and providing timely and comprehensive transitional care after hospitalizations were characteristics of successful care coordination programs.[213] Our project, the Vulnerable Patient Network incorporates these components into the program and furthers them by adding additional services such examinations and clinical decision making to changing urinary catheters, labs, vaccinations. The team we propose to put in place would be able to address all of these needs in a coordinated and fluid fashion.

Project Components

We plan to engage in continuous quality improvement activities such as: identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Reasons for selecting outcome measures

The milestones and metrics we chose for this project are focused on identifying and intervening on high risk patients who are high utilizers of healthcare services and are unable or unwilling to receive care in an ambulatory care setting.

There is one point of clarification needed around the target population for this project. We define the target population as the following:

- Numerator: The number of patients enrolled in the program
- Denominator: The number of patients referred from the hospital as identified by Care Coordinators/Navigators as possible candidates based on identified risk factors including but not limited to: homebound, disabled, multiple chronic diseases, polypharmacy or any other medical or social conditions limiting patients' ability to access care in ambulatory care setting

[213] Brown, RS. Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high risk patients. *Health Aff*. 2012 June; 21(6): 1156-1165.

The reason we selected outcome measures related to Quality of Life and Activities of Daily living was in order to emphasize the importance for the Care Team to identify and assess non-clinical barriers that may be impeding the patient from receiving the optimal level of care necessary to maintain and sustain their health status.

Unique community need identification number the project addresses: CN.3- Healthcare Capacity and CN.12 Emergency Department Usage and Readmissions

How the project significantly enhances an existing delivery system reform initiative
This project does not receive any federal funds and is a new initiative. It is focused on addressing the complex needs of the highest risk patients by bringing care into their homes.

Related Category 3 Outcome Measures
The Category 3 Outcomes chosen for this project are based upon expected improvement for quality of life and activities of daily living. Many of the components included in Quality of Life and Activities of Daily living assessments help the care team to identify barriers to care and increase compliance. Both measures would also help to periodically and regularly assess QOL and ADL measures to keep an updated record of the patient's barriers to care.

Outcome Measure #1: IT-10.1 Quality of Life (**Standalone measure**).
Quality of Life assessments such as the SF-36 or AQoL measure components such as: illness, independent living, social relationships, physical senses and psychological wellbeing and will be important to measure in the high risk and vulnerable patients we intend to serve.[214] Understanding social and physical attributes of the patient will be essential in determining their feasibility of following protocols and regimens that will optimize their healthcare. We plan on conducting a QOL assessment every 6 months on patients who have been in the program for at least 6 months. Improvement will be measured from the time the patient is enrolled to time of survey administration.

Outcome Measure #2: IT-10.2 Activities of Daily Living (**Standalone measure**).
Measurement of the activities of daily living is critical because they have been found to be significant predictors of paid home care , use of hospital services, living arrangements, use of physician, insurance coverage and mortality.[215] While ADLs are typically used with the elderly population, the complexity and nature of the high risk uninsured/Medicaid patients warrants this assessment as well. Monitoring the progress or decline of factors such as bathing, feeding, continence, transferring, toileting and dressing are immediate predictors of any issues or barriers that patients may be experiencing.[216] We may need to consider using the Lawton IADL

[214] Hawthorne, G. The assessment of quality of life instrument: a psychometric measure of health related quality of life. *Qual Life Res.*8(3):209-24 (1999)
[215] Measuring ADLs Across National Surveys: http://aspe.hhs.gov/daltcp/reports/meacmpes.htm
[216] Katz, Sidney. 1983. "Assessing Self-Maintenance: Activities of Daily Living, Mobility, and Instrumental Activities of Daily Living." *Journal of the American Geriatrics Association* 31:721-727.

scale for this population as it involves more complex activities such as: shopping, laundry, responsibility for own medications, etc.[217] We plan on conducting the ADL assessment every 6 months and patients that have been in the program for 6 months. The improvement will be measured from the time that patients enroll in the program to survey conduction.

Relationship to other Projects

121790303.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
Patients that are in the Vulnerable Patient Network can come from the Baylor Clinic. Patients that are identified as high risk from the Baylor Clinic are candidates for the VPN program.

Category 4 Population-focused improvements

This project will help to support, reinforce and enable Category 4 population focused improvements through project design and appropriate intervention for targeted populations:

The thought here is that if patients receive the care they need they will have improved clinical outcomes and fewer ED or inpatient admissions.
RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.7, RD-1.8, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7, RD-4.1, RD-4.2

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

Care Coordination models require an initial connection but also require resources to triage patients to. Once a patient is identified to need a PCP/PCMH or another community resource, it becomes the Region's responsibility to ensure there are outlets for these patients to receive the care they need.

Performing Provider	Unique Project Number
Baylor Medical Center at Irving	121790303.2.4
Baylor University Medical Center	139485012.2.4
Children's Medical Center	138910807.2.4
Doctors Hospital at White Rock (Tenet)	094194002.2.2
Parkland Health & Hospital System	127295703.2.9
University of Texas Southwestern – Faculty	126686802.2.5
University of Texas Southwestern – Hospital	175287501.2.3

Plan for Learning Collaborative. We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

[217] Lawton, M. Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living. *The Gerontologist* 9:179-186.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced our projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. That model computes separate values for impacts on the health care system, the individual and the community. ***Baylor Medical Center at Garland*** defined the population that will be directly impacted by the project as the underserved/ uninsured patients are considered high risk both clinically and socioeconomically. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 4. We believe when a person is connected to comprehensive care, available to them in their homes, compliance and outcomes both improve. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a *3.* We believe when a person is positively impacted, their ED utilization decreases, community resource burdens are relieved and a greater number of people receive care. In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121790303.2.4	***2.12.2***	***CQI***	***IMPLEMENT PILOT INTERVENTION IN CARE TRANSITIONS-*** *VULNERABLE PATIENT NETWORK (VPN)*	
Baylor Medical Center at Garland				*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.16* *121790303.3.17*	*3.IT-10.1* *3.IT-10.2*	*Quality of Life (**Standalone measure**)* *Activities of Daily Living (**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-5]: Using a validated risk assessment tool, create a patient identification system Metric 1 [P-5.1]: Patient stratification system Baseline/Goal: Develop and validate risk assessment tool Data Source: Documentation tool options and assessments Milestone 1 Estimated Incentive Payment *(maximum amount):* $125,831 **Milestone 2** [P-7]: Develop a staffing and implementation plan to complete goals/objectives of the care transitions program Metric 1 [P-7.1]: Documentation of staffing plan Baseline/Goal: Create staffing plan for care team Data Source: Staffing and implementation plan Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 125,831	**Milestone 3** [P-5]: Using a validated risk assessment tool, create a patient identification system Metric 1 [P-5.1]: Patient stratification system Goal: Implement risk assessment tool Data Source: Submission of risk assessment tool and patient stratification report and description of provider utilization report of findings Milestone 3 Estimated Incentive Payment: $91,517 **Milestone 4** [P-9]: Implement a case management related registry Metric 1 [P-9.1]: Documentation of registry implementation Goal: Implement and validate registry Data Source: Registry reports demonstrating case management functionality Milestone 4 Estimated Incentive Payment: $91,517 **Milestone 5** [I-15]: Improve care transitions using innovative project option Metric 1 [I-15.1]: Increase percentage of target population reached Goal: Increase percentage of target population reached by 15% or at least 15	**Milestone 6** [I-15]: Improve care transitions using innovative project option Metric 1 [I-15.1]: Increase percentage of target population reached Goal: Increase percentage of target population reached by 25% or at least 30 patients enrolled over DY2 Numerator: Number of patients enrolled in intervention Denominator: Number of patients referred from the hospital as potential candidates based on risk factors Data Source: Documentation of target population reached Metric 2 [I-15.2]: Evaluate the intervention(s) Goal: Report number of patients transitioned by type of transition Data Source: data file of all transitioned patient in one year Metric 3 [I-15.3]: Percentage of patients, regardless of age discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary care physician or other health care professional	**Milestone 7** [I-15]: Improve care transitions using innovative project option Metric 1 [I-15.1]: Increase percentage of target population reached Goal: Increase percentage of target population reached by 35% or at least 50 patients enrolled over DY2 Numerator: Number of patients enrolled in intervention Denominator: Number of patients referred from the hospital as potential candidates based on risk factors Data Source: Documentation of target population reached Metric 2 [I-15.2]: Evaluate the intervention(s) Goal: Report number of patients transitioned by type of transition Data Source: data file of all transitioned patient in one year Metric 3 [I-15.3]: Percentage of patients, regardless of age discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary

121790303.2.4	***2.12.2***	***CQI***	***IMPLEMENT PILOT INTERVENTION IN CARE TRANSITIONS-*** *VULNERABLE PATIENT NETWORK (VPN)*	
Baylor Medical Center at Garland				*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.16* *121790303.3.17*	*3.IT-10.1* *3.IT-10.2*	*Quality of Life (**Standalone measure**)* *Activities of Daily Living (**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)**
	patients enrolled over DY2 Numerator: Number of patients enrolled in intervention Denominator: Number of patients referred from the hospital as potential candidates based on risk factors Data Source: Documentation of target population reached Metric 2 [I-15.2]: Evaluate the intervention(s) Goal: Report number of patients transitioned by type of transition Data Source: data file of all transitioned patient in one year Metric 3 [I-15.3]: Percentage of patients, regardless of age discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary care physician or other health care professional designated for follow-up within 24 hours of discharge Goal: Report percentage of patients for whom a transition record was transmitted to a facility or primary care of other health care professional designated for follow-up within 24 hours of discharge Data Source: data file of all transitioned patient in one year Metric 4 [I-15.4]: Percentage of patients		designated for follow-up within 24 hours of discharge Goal: Report percentage of patients for whom a transition record was transmitted to a facility or primary care of other health care professional designated for follow-up within 24 hours of discharge Data Source: data file of all transitioned patient in one year Metric 4 [I-15.4]: Percentage of patients regardless of age, discharged from an emergency department to ambulatory care or home health, or their caregiver, who received a transition record at the time of ED discharge Goal: Report number of patients who received a transition record at the time of ED discharge including: major procedures and tests performed during ED visit, principal diagnosis (or chief complaint), patient instructions, plan for follow up care (or statement that none was required), list of new medications and changes to continued medications that patient should take after ED discharge Data Source: EHR Milestone 6 Estimated Incentive	care physician or other health care professional designated for follow-up within 24 hours of discharge Goal: Report percentage of patients for whom a transition record was transmitted to a facility or primary care of other health care professional designated for follow-up within 24 hours of discharge Data Source: data file of all transitioned patient in one year Metric 4 [I-15.4]: Percentage of patients regardless of age, discharged from an emergency department to ambulatory care or home health, or their caregiver, who received a transition record at the time of ED discharge Goal: Report number of patients who received a transition record at the time of ED discharge including: major procedures and tests performed during ED visit, principal diagnosis (or chief complaint), patient instructions, plan for follow up care (or statement that none was required), list of new medications and changes to continued medications that patient should take after ED discharge Data Source: EHR

121790303.2.4	***2.12.2***	***CQI***	***IMPLEMENT PILOT INTERVENTION IN CARE TRANSITIONS-*** *VULNERABLE PATIENT NETWORK (VPN)*	
Baylor Medical Center at Garland				*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.16* *121790303.3.17*	*3.IT-10.1* *3.IT-10.2*	*Quality of Life (**Standalone measure**)* *Activities of Daily Living (**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)**
	regardless of age, discharged from an emergency department to ambulatory care or home health, or their caregiver, who received a transition record at the time of ED discharge Goal: Report number of patients who received a transition record at the time of ED discharge including: major procedures and tests performed during ED visit, principal diagnosis (or chief complaint), patient instructions, plan for follow up care (or statement that none was required), list of new medications and changes to continued medications that patient should take after ED discharge Da ta Source: EHR Milestone 5 Estimated Incentive Payment: $91,517	Payment: $275,348	Milestone 7 Estimated Incentive Payment: $227,461
Year 2 Estimated Milestone Bundle Amount: $ 251,662	Year 3 Estimated Milestone Bundle Amount: $274,550	Year 4 Estimated Milestone Bundle Amount: $275,348	Year 5 Estimated Milestone Bundle Amount: $227,461
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,029,021			

Project Option 2.11.3 – Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

RHP Project Identifier: 121790303.2.5 – Pass 2
Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Provider: Baylor Medical Center at Garland is a fully accredited, 240-bed medical center serving the residents of Garland, Texas, and the neighboring communities. Baylor Garland has 582 physicians on its medical staff representing a wide range of specialties. Baylor Garland's service area represents a population of 640,000.

Intervention(s): This project will provide medication management and reconciliation services to uninsured and Medicaid patients at the Baylor Clinic on the Baylor Medical Center at Garland campus. Patients who are 150% or below the FPL and/or have chronic illnesses can qualify for prescription assistance. A clinical pharmacist will be responsible for oversight of prescriptions, educate patients about how and why to take their medications and review utilization, appropriateness and efficacy of medications that patients have been prescribed.
New v. existing initiative: This project is a new initiative and contributes to creating a complete PCMH for underserved patients.

Need for the project: Non-compliance to medications can lead to complications and clinical exacerbations that are often avoidable with proper management and education. Medications are an important part of a patient's care regimen but can become an impediment to care when issues such as access or cost become prevalent. This project will help to overcome these issues.

Target population: Baylor Clinic patients who have multiple medications, chronic diseases and/or have demonstrated need for prescription assistance. At least 90% of patients served will be Uninsured/Medicaid.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide medication management to 180 patients.

Category 3 outcomes: Category 3 outcomes for this project do not have any baseline data and improvements are based on ranges of current performance.

- **IT-1.2** Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs (Non- standalone measure). Our goal is to increase the appropriate monitoring tests from at least 2% in DY3 to at least 6% in DY5.
- **IT-1.4** Annual monitoring for patients on persistent medications– diuretic (Non-standalone measure). Our goal is to increase the appropriate monitoring tests from at least 2% in DY3 to at least 6% in DY5.

- **IT-1.5** Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)**.** Our goal is to increase the appropriate monitoring tests from at least 2% in DY3 to at least 6% in DY5.
- **IT-1.19** Antidepressant Medication Management - (Standalone measure). Our goal is to increase effective acute phase treatment by 5% in DY3 to 15% in DY5 and to increase continuous phase treatment by 3% in DY3 to 7% in DY5.

Project Description

This project option combines project options 2.11.1- Implement interventions that put in place teams, technology and processes to avoid medication errors and 2.11.2- Evidence based interventions that put in place the teams, technology and processes to avoid medication errors. The project option we chose combines the components of both of these project options but focuses on medication management and compliance in the ambulatory setting within the patient's Baylor Clinic PCMH. Based on current estimates by our providers, we anticipate that more than 50% of patients in the Baylor Clinic have five or more medications. Ensuring that these medications are 1) appropriate, 2) taken correctly, 3) managed and 4) accessible will be important to improve clinical outcomes. By combining two of the project options 2.11.1 and 2.11.2 to create an "other" option encompasses both a process for avoiding medication errors and evidence based interventions to avoid medication errors. We intend to utilize a clinical pharmacist who will review patient mediations for those patients who have multiple prescriptions on a regular basis to ensure that medications are appropriate and to ensure the patient understands how and why they are taking the medications. Additionally, we plan to help patients obtain the medications they need through implementing a prescription assistance program to help patients who are eligible, qualify for mediations and provide medications to those patients who cannot afford prescriptions. We will attempt to provide medications at little to no cost for patients who are 150% below the federal poverty level, have one or more chronic diseases and remain compliant with their appointments and care regimens. Through this benefit and clinical pharmacist oversight and management, we expect adherence and compliance to medications will increase. The additional advantage to embedding this team within the PCMH is patients will receive comprehensive care management to address their needs in one care venue.

Goals and Relationship to Regional Goals

The goals for this project are: 1) to provide prescriptions at little to no cost for patients that qualify or help patients enroll in programs to receive their medications, 2) provide clinical pharmacist oversight to ensure that medications are appropriate and adhered to, 3) patients understand their medications and reasons for taking them 4) improve clinical outcomes related to adhering to a medication regimen. The regional goals around managing chronic disease, ED utilization and behavioral health are all addressed through this project. Managing medications has ancillary effects on outcomes of multiple regional goals. If patients have access to and adhere to their prescriptions, chronic diseases and behavioral health issues would be under better control and there would be fewer exacerbations and visits to the ED. This program is also

a mechanism to improve cost savings for the region through monitoring utilization, finding generic prescriptions where appropriate and avoiding costly complications and expensive ED/inpatient utilization.

Challenges

Challenges with the underserved population and medication management pose one of the most difficult hurdles to overcome in their care. First, the uninsured and Medicaid populations are highly transient and may not maintain the same PCMH for an extended period of time. This causes gaps in their medication regimen and can often lead to clinical exacerbations. Another challenge is access to medications and affordability. Patients who do not live near a pharmacy to fill their prescriptions or cannot afford to fill them will forgo this part of their care or ration the medications they have, leading to complications and escalations in their conditions. One trend we have seen in RHP 9 is indigent patients will go from ED to ED across the region to receive pain medications and because there is little coordination between hospital systems, there is no consistent record of the medications these patients receive. Lastly, patients that are polypharmacy often do not understand how to take their mediations appropriately or understand why they need the prescription at all. This lack of understanding also leads to non-compliance. With this project, we plan to address these challenges by providing medications at little to no cost for those patients that qualify, help patients that are eligible get on prescription assistance programs, provide prescriptions in the Baylor Clinic or nearby on the Baylor campus and offer clinical pharmacist oversight to monitor the patients' prescriptions and encourage compliance to a medication regimen.

5-year Expected Outcome for Provider and Patients

The 5-year expected outcomes for this project include: 1) a minimum of 180 patients with medication management in a PCMH setting, 2) increased frequency of medication reconciliation and management, 3) greater literacy around medication regimens and purposes, 4) efficient and effective utilization of medications for patients and 5) make the clinical pharmacist part of the PCMH care team. We through proactive management of mediations for the uninsured and Medicaid populations that clinical outcomes will improve, there will be fewer exacerbations of patient diseases.

Starting Point/Baseline

Baylor clinics have not historically provided any type of formal medication management or prescription assistance type program to patients. This is a new program that will be offered. Based on historical data, almost 50% of patients have five or more prescriptions. We anticipate that on average about 5-10% of high risk Baylor Clinic patients will need focused and frequent medication management services. We will have to establish the baseline in DY2 for the particular medications mentioned in the Category 3 outcomes and to determine the scope of high risk and polypharmacy patients.

Rationale

We selected this project for multiple reasons: 1) to offer a complete suite of services to patients in a Baylor Clinic PCMH ranging from chronic disease and behavioral management, basic primary care, specialty care and medications, 2) provide regular medication management and reconciliation to ensure appropriate utilization and adherence to prescriptions, 3) improve clinical outcomes by enforcing a medication regimen with patients and 4) improve adherence to medications by offering assistance in obtaining them. Successful programs that focus on coordinating care for patients include a medication management component.[218] Our overall goal is to create a PCMH for uninsured and Medicaid patients that is comprehensive and has co-located services to allow for greater convenience and compliance for patients. The total economic impact of medication non-adherence — which contributes to costly health complications, worsening of disease progression, and preventable utilization — has been estimated to be as much as $290 billion.[219] For patients with diabetes, those with low levels of adherence have almost twice the total annual healthcare costs of those with high levels of adherence ($16,498 versus $8,886).[220] The New England Healthcare Institute cited four components to improving medication management: 1) creating health care teams, 2) patient engagement and education, 3) payment reform and 4) leveraging health information technology.[221] This project addresses all of these components by 1) integrating the clinical pharmacist into the PCMH team, 2) educating the patient on why and how to take their medications, 3) offering prescription assistance and little to no cost medications for those who qualify and 4) using the Baylor Clinic electronic health record to monitor prescription regimens, fulfillments and utilization. There have been studies published stating that giving patients medications for free does not promote utilization and adherence.[222] In a study published in the New England Journal of Medicine, insured patients who were discharged from the hospital and had their prescriptions fully covered still only had adherence rates of 40-50%.[223] We will control for this in two ways: 1) we will not offer prescriptions for free unless the patient is 150% or below the FPL and/or has at least 1 chronic disease and 2) we will require that a patient is seen regularly in the Baylor Clinic to continue to receive their medications.

Project Components

We have chosen applicable components from project options 2.11.1 and 2.11.2 to create our project around medication management.

a. Develop criteria and identify targeted patient populations that are at high risk for developing complications, co-morbidities and/or utilizing emergency care services: *We will use our electronic health record to identify polypharmacy patients, patients who are on chronic disease medications and/or are high utilizers of the ED*

[218] Brown, RS. Six features of Medicare coordinated demonstration programs that cut hospital readmissions of high risk patients. *Health Aff*. 2012 June; 31(6):1156-1165.

[219] McKethan, A and Benner, J. Seizing the opportunity to improve medication adherence. *Health Aff.* 2012 August.

[220] New England Healthcare Institute.Thinking outside the pillbox: a systemwide approach to improving medication adherence for chronic disease.Aug 09

[221] New England Healthcare Institute.Thinking outside the pillbox: systemwide approach to improving medication adherence for chronic disease. Aug 09.

[222] McKethan, A and Benner, J. Seizing the opportunity to improve medication adherence. *Health Aff.* 2012 August.

[223] Choudhry, NK, Avorn, J, et. al. Full coverage for preventive medications after myocardial infarction. N Engl J Med 2011; 365:2088-2097

b. Develop tools to provide education and support to those patients at highest risk of an adverse drug event or medication error. *The clinical pharmacist we use for this program will help to educate the patient on these topics. We will ensure that materials are multilingual as well.*

c. Conduct root cause analysis of potential medication errors or adverse drug events and develop/implement processes to address those causes: *As one of our metrics, we will be designing the workflow for the clinical pharmacist and we will add this component into the plan*

d. Implement pharmacist led chronic disease medication management services in collaboration with primary care and other healthcare providers: *The clinical pharmacist will be co-located in the Baylor Clinic and will interface with the PCMH team on a regular basis*

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. *This project will be part of an overall Baylor initiative that will be analyzing and evaluating the progress and challenges/barriers for all DSRIP projects. We will focus on identifying key challenges associated with the expansion and opportunities to scale the project where appropriate.*

Reasons for selecting outcome measures

The milestones and metrics we chose for this project are focused on increasing the number of patients who receive medication management services and by having outcomes that specifically focus on medications, this will encourage the care team to manage and monitor medications more frequently and with higher scrutiny. Although medication management is part of the patient's overall care in a Baylor Clinic, these milestones, metrics and outcomes will put a greater emphasis on ensuring that mediations are appropriate, regularly reconciled, adhered to and are utilized in order to improve clinical outcomes for patients. The outcome measure medications that we chose: ACE/ARB inhibitors, diuretics, anticonvulsants and antidepressants are drugs that are regularly used by our Baylor Clinic patients. Since many of our patients have hypertension and CHF, adherence improvement to these drugs will help to facilitate better outcomes.

Unique community need identification number the project addresses:

CN.11 Patient Safety and Quality and CN.4 Primary Care and Pediatrics

How the project significantly enhances an existing delivery system reform initiative

This project does not receive any federal funds and is a new initiative. It is focused on providing prescriptions for patients in need and ensuring that utilization of these prescriptions is appropriate and (cost and clinically) effective.

Related Category 3 Outcome Measures

The Category 3 outcomes for this project focus on medication management and monitoring for specific drugs that many of our Baylor Clinic use. These medications are also associated with complex chronic diseases and behavioral health issues. These drugs are an important part of a patient's care regimen to keep their conditions well controlled.

Outcome Measure #1: IT-1.2 Annual monitoring for patients on persistent medications angiotensin
converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non- standalone measure).
Approximately 33% of Baylor Clinic patients are on an ACE/ARB medication regimen. Enforcing annual monitoring will improve quality and reconcile the patient's medication to ensure it is still appropriate. In a recent study in the New England Journal of Medicine, compliance to antihypertensives was 41%, beta blockers was 49% and statins were 55% after a patient suffered from an AMI.[224] We believe through consistent, proactive management and encouraging patient accountability for taking medications, these rates should increase.

Outcome Measure #2: IT-1.4 Annual monitoring for patients on persistent medications–diuretic (Non- standalone measure)
Approximately 33% of Baylor Clinic patients on a diuretic medication regimen. Enforcing annual monitoring will improve quality and reconcile the patient's medication to ensure it is still appropriate. A study that observed the correlation between a diuretic regimen and cardiovascular related hospitalizations found that patients who take the appropriate dose of diuretics at the appropriate time had a decrease risk of cardiovascular and heart failure related hospitalizations. A large component of the successful adherence was attributed to patient education and engagement in the medication regimen.[225]

Outcome Measure #3: IT-1.5 Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)
Only about 5% of Baylor Clinic patients are on an anticonvulsant medication regimen. This may be because there are no formal behavioral health programs in the Baylor Clinic, it is possible that identification of BH issues is low and utilization of anticonvulsants would increase with an increased emphasis on identifying BH issues. A study in Psychiatric Services found that 50% of patients that were given anticonvulsant prescriptions to treat bipolar disorder were non-

[224] Choudhry, NK, Avorn, J, et. al. Full coverage for preventive medications after myocardial infarction. N Engl J Med 2011; 365:2088-2097

[225] Chui, M. A., Deer, M., Bennett, S. J., Tu, W., Oury, S., Brater, D. C. and Murray, M. D. (2003), Association Between Adherence to Diuretic Therapy and Health Care Utilization in Patients with Heart Failure. Pharmacotherapy, 23: 326–332. doi: 10.1592/phco.23.3.326.32112

adherent.[226] This issue can be resolved by explaining the risks v. benefits for taking an anticonvulsant.

Outcome Measure #4: IT-1.19 Antidepressant Medication Management - (Standalone measure) Approximately 20% of Baylor Clinic patients on an antidepressant medication regimen. According to the Community Health Needs Assessment, behavioral health is a major issue in the region. The top 10 utilizers in the region had BH related issues.[227] While antidepressants are not the solution to this problem, managing depression can have other positive ancillary effects on clinical adherence and avoidance of BH exacerbations. This outcome enforces both short and long term adherence to this drug in order to avoid adverse events for patients. An article in the Journal of Clinical Psychiatry, evidence was found "…to support collaborative care interventions in a primary care setting demonstrated significant improvements in antidepressant drug adherence during the acute and continuous phase of treatment and were associated with clinical benefit, especially in patients suffering from major depression and were prescribed adequate dosages of antidepressant medication.[228]" Our project supports this methodology.

Relationship to other Projects

121790303.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
This medication management and prescription assistance program will be available to patients who are Baylor Clinic patients. The program will be incorporated into the overall care team and management of the patient.

Category 4 Population-focused improvements

This project will help to support, reinforce and enable Category 4 population focused improvements through project design and appropriate intervention for targeted populations: The thought here is that if patients take the appropriate medications in the right dose and correct regimen, the following improvements can be expected:
RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.8, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7, RD-3, RD-4.1, RD-4.2

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

TBD

Plan for Learning Collaborative

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may

[226] Sajattovic, M, et. al. Treatment adherence with lithium and anticonvulsant medications among patients with bipolar disorder. *Psychiatric Services*. 58(6):855-63. 2007.
[227] RHP 9 Community Health Needs Assessment
[228] Vergouwen, AC, et. al. Improving adherence to antidepressants: a systematic review of interventions. *J Clin Psychiatry.* 64(12):1415-20. 2003.

enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same process and technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced our projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor Medical Center at Garland defined the population that will be directly impacted by the project as the underserved/uninsured patients that need prescription assistance and medication management services that are patients at a Baylor Clinic PCMH on the ***Baylor Medical Center at Garland*** campus. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3. We believe this to be the correct number because, when a person is on the correct prescription and on an appropriate medication regimen, they are better able to manage their illnesses and have better clinical outcomes. To determine the value to the community of each, we concluded that, on a scale of 1 – 5, the value of this project is a *3.* We believe this to be the correct number because, when a person is positively impacted, unnecessary drug utilization decreases, patients are able to become well and resume being active and productive members in society.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121790303.2.5	***2.11.3***	***2.11.3 (A-F)***	***OTHER PROJECT OPTION- EVIDENCE BASED INTERVENTIONS THAT PUT IN PLACE TEAMS, TECHNOLOGY AND PROCESSES TO ENSURE MEDICATION COMPLIANCE AND MANAGEMENT- MEDICATION MANAGEMENT AND PRESCRIPTION ASSISTANCE PROGRAM***
Baylor Medical Center at Garland			*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.18* *121790303.3.19* *121790303.3.20* *121790303.3.21*	*3.IT-1.2* *3.IT-1.4* *3.IT-1.5* *3.IT-1.19*	*Annual monitoring for patients on persistent medications angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non- standalone measure)* *Annual monitoring for patients on persistent medications– diuretic (Non- standalone measure)* *Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)* *Antidepressant Medication Management - (Standalone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Implement/expand a medication management program/system Metric 1 [P-1.1]: Program elements Baseline/Goal: Determine program elements: people, processes and technologies Data Source: Documentation of program and written medication management plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $111,586 **Milestone 2** [P-2]: Develop criteria and identify patient populations Metric 1 [P-2.1]: Establish evidence based criteria for medication management planning in target population based on assessment of population needs Baseline/Goal: Conduct needs	**Milestone 3** [P-1]: Implement/expand a medication management program/system Metric 1 [P-1.1]: Program elements Baseline/Goal: Create workflow and medication management plans Data Source: Documentation of written medication management plan and provider workflow Milestone 3 Estimated Incentive Payment *(maximum amount):* $81,156 **Milestone 4** [P-4]: Implement an evidence based program based on best practices for medication reconciliation to improve medication management and continuity between acute care and ambulatory setting Metric 1 [P-4.1]: Written plan to provide medication reconciliation as part of transition from acute care to	**Milestone 6** [I-9]: Manage medications for targeted patients Metric 1 [I-9.1]: Increase number of patients (meeting criteria for chronic condition) contacted or receiving medication management Goal: Provide medication management services to at least 150 patients over DY2 Data Source: E.H.R. Milestone 6 Estimated Incentive Payment *(maximum amount):* $244,176	**Milestone 7** [I-9]: Manage medications for targeted patients Metric 1 [I-9.1]: Increase number of patients (meeting criteria for chronic condition) contacted or receiving medication management Goal: Provide medication management services to at least 180 patients over DY2 Data Source: E.H.R. Milestone 7 Estimated Incentive Payment *(maximum amount):* $201,711

121790303.2.5	***2.11.3***	***2.11.3 (A-F)***	***OTHER PROJECT OPTION- EVIDENCE BASED INTERVENTIONS THAT PUT IN PLACE TEAMS, TECHNOLOGY AND PROCESSES TO ENSURE MEDICATION COMPLIANCE AND MANAGEMENT- MEDICATION MANAGEMENT AND PRESCRIPTION ASSISTANCE PROGRAM***
Baylor Medical Center at Garland			*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.18* *121790303.3.19* *121790303.3.20* *121790303.3.21*	*3.IT-1.2* *3.IT-1.4* *3.IT-1.5* *3.IT-1.19*	*Annual monitoring for patients on persistent medications angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non- standalone measure)* *Annual monitoring for patients on persistent medications– diuretic (Non- standalone measure)* *Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)* *Antidepressant Medication Management - (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)**
assessment to determine target population and medication needs Data Source: Written criterion for target population and program participation. Milestone 2 Estimated Incentive Payment *(maximum amount):* $111,586	ambulatory care Baseline/Goal: Create plan for medication reconciliation Data Source: Documentation of program policies and procedures that ensure medication reconciliation upon admission and discharge at each care setting Milestone 4 Estimated Incentive Payment *(maximum amount):* $81,156 **Milestone 5** [I-9]: Manage medications for targeted patients <u>Metric 1</u> [I-9.1]: Increase number of patients (meeting criteria for chronic condition) contacted or receiving medication management Goal: Provide medication management services to at least 100 patients over DY2 Data Source: E.H.R. Milestone 5 Estimated Incentive		

121790303.2.5	***2.11.3***	***2.11.3 (A-F)***	***OTHER PROJECT OPTION- EVIDENCE BASED INTERVENTIONS THAT PUT IN PLACE TEAMS, TECHNOLOGY AND PROCESSES TO ENSURE MEDICATION COMPLIANCE AND MANAGEMENT- MEDICATION MANAGEMENT AND PRESCRIPTION ASSISTANCE PROGRAM***
Baylor Medical Center at Garland			*121790303*
Related Category 3 Outcome Measure(s):	*121790303.3.18* *121790303.3.19* *121790303.3.20* *121790303.3.21*	*3.IT-1.2* *3.IT-1.4* *3.IT-1.5* *3.IT-1.19*	*Annual monitoring for patients on persistent medications angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non- standalone measure)* *Annual monitoring for patients on persistent medications– diuretic (Non- standalone measure)* *Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)* *Antidepressant Medication Management - (Standalone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Payment *(maximum amount):* $81,156		
Year 2 Estimated Milestone Bundle Amount:: $ 223,172	Year 3 Estimated Milestone Bundle Amount: $243,469	Year 4 Estimated Milestone Bundle Amount: $244,176	Year 5 Estimated Milestone Bundle Amount: $201,711
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $912,528			

Project Option 2.2.2 – Expand Chronic Care Management Model - Create Chronic Disease management and Prevention Program

RHP Project Identifier: 121776204.2.1
Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Provider: Located in the heart of the Dallas-Fort Worth Metroplex, Baylor Irving serves Irving, Las Colinas and the surrounding communities. The not-for-profit 296-bed hospital offers advanced treatment capabilities in cardiology, orthopedics, oncology, digestive disorders, diagnostic imaging, physical medicine and emergency care. Baylor Irving's service area represents a population of 546,000.

Intervention(s): The project purpose is to provide focused education and point of care testing for underserved patients who have diabetes, CVD and/or Respiratory disease that are in need of education, clinical management and training within a primary care setting. We will co-locate primary care and chronic disease management services to improve clinical outcomes. This project is new because it will provide CHF and Asthma education and point of care testing, all which have not been done before. We have had some Diabetes education in our Clinics but not a formal and focused program for the Medicaid/Uninsured population.

Need for the project: One of the major identified by the Community Health Needs Assessment for Region 9 included Chronic Disease. Components of patient education and helping patients to understand their illness, how to better manage it, how to coordinate their lifestyle choices and offering point of care testing in order to achieve optimal health outcomes are essential in population management of chronic disease

Target population: Approximately 275,000 individuals in Dallas County have Diabetes. 19.6% of Dallas County has Asthma, which equates to 473,000 people. CHF accounts for about 200 deaths per 100,000 individuals in Dallas County. The underserved segment of this population is who we will target. We expect that this program's participants will be 85-90% Medicaid/Uninsured patients.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide chronic disease education and point of care testing for 688 patients in the Irving area.

Category 3 outcomes: Category 3 outcomes for this project were chosen because: 1) the ambulatory setting of the project and 2) historical trends of metrics that had material impact on patients in a 2-3 year time period.

- IT-1.10: Diabetes Care: HbA1c Poor Control. Our goal is to decrease the number of patients with uncontrolled HbA1cs (> 9.0%) from 10.3% currently to 8.8% (or 1.5% improvement-reduction over baseline) in DY5.

- IT-11.1: Diabetes Care: BP Control (< 140/80 mmHg). Our goal is to increase the number of diabetic patients in good BP control (< 140/80 mmHg) from 58.9% to 64.8% (or 5.9% improvement over baseline) in DY5.

- IT-1.13: Diabetes Care: Foot Exam. Our goal is to increase the number of diabetic patients who receive foot exams from 73.4% currently to 80.6% (or 7.2% improvement over baseline) in DY5.

Project Description

The Baylor Clinic on the Baylor Medical Center at Irving campus, would house a carved out chronic disease management program to provide focused and dedicated education and care for patients (including Medicaid/Uninsured) with Diabetes, Cardiovascular Diseases (CVD) (i.e.: Congestive Heart Failure) and Respiratory Diseases (Asthma/Chronic Obstructive Pulmonary Disease) within a primary care setting. We expect that this program's participants will be 85-90% Medicaid/Uninsured patients. Specific staff, comprised of CHWs and Nurse Care Managers, would address the complex clinical and prevention needs of these patients and spend time specifically on management of these diseases. The focus of this time and education with patients would not only entail clinical counseling, but also include prevention components to focus on lifestyle issues and self-management. The other key advantage that patients will receive as part of this program is point of care testing for Diabetes (HbA1c testing and glucose testing using test strips) and Asthma (Peak Flow Meter Assessments). We believe this will overcome the barrier of patients' non-compliance with completing lab orders and any financial or transportation issues that would arise in obtaining these important lab results.

We plan to leverage the expertise and experience of both the Diabetes Health and Wellness Institute (Baylor entity in South Dallas) and Baylor Clinics to provide staff education, develop competencies, and create protocols that will result in a complete and robust program tailored for multiple community settings. The Diabetes Health and Wellness Institute would house this staff and appropriately triage and manage providers to see patient at Baylor Clinics based on volume and demand parameters. Baylor Clinics have had previous success in managing patients with chronic disease through the creation and development of a community health worker model (CHW). These successes and competencies will be leveraged to create programs around CVD and Respiratory illnesses.

The project goals for this program include: 1) increasing health literacy around chronic illnesses for patients in the community, 2) educate and teach self-management techniques for patients to manage their chronic diseases, 3) augmenting RN care managers with CHWs to serve a greater number of patient through a carved out, focused care model, 4) increasing the number of patients who are screened and monitored for their chronic diseases using point of care testing and 5) increase education for patients with CHF and Asthma/COPD (2 disease states previously not offered). The purpose for a project in this area is to help identify patients with

chronic diseases and provide them with treatment and education in a proactive fashion so that downstream complications can be avoided and ED/inpatient utilization can decrease.

One of the major identified by the Community Health Needs Assessment for Region 9 included Chronic Disease[229]. Components of patient education and helping patients to understand their illness, how to better manage it and how to coordinate their lifestyle choices to achieve optimal health outcomes are essential in population management of chronic disease. This project coincides with this need and focuses on education, lifestyle management, proactive counseling and decision making and clinical improvement. This leads to lower ED visits for acute issues related to chronic diseases and helps patients utilize costly services in the Region.

Challenges

Underserved patients experience multiple barriers to effectively manage their chronic illnesses. These include lack of knowledge, lack of social support, poor diets, insufficient physical activity, and limited access to care due to financial and transportation issues. By co-locating the chronic care management program within the primary care clinic, patients can receive medical care and chronic disease support at the same time. Additionally, the PCP's medical management is informed by the chronic care management team's interactions with the patient, which, in our experience, elicits new information regarding lifestyle and barriers to health. The RN/CHW model will be structured so that patient education is delivered in a format and context that is understandable and enjoyable for the patient. Lastly, the education and counseling will include lifestyle and self-management techniques so that this population can find ways to care for themselves that is relevant to their daily lives.

5-year Expected Outcome for Provider and Patients

The expected 5-year outcomes are that: 1) at least 688 patients will have served by the Chronic Care Management model at the Baylor Clinic, 2) we expect better clinical outcomes around HbA1c, foot exam completion and BP control, 3) more patients in the community will have had a point of care test completed for their diabetes or asthma which will provide real time results and opportunities for improvement for the patient and provide, 4) increase literacy in the Irving community around chronic diseases and 5) decrease rates of avoidable/unnecessary complications (i.e. amputations) due to chronic diseases.

Starting Point/Baseline

Currently, the Baylor Clinic on the Baylor Medical Center at Irving offers a limited program focused on diabetes education. Of the patients enrolled in the program, approximately 10% of clinic patients have an HbA1c > 9.0. This baseline is not directly comparable to the proposed project for chronic care management because we will be including CHF and Asthma/COPD patients as well as part of the initiative.

We estimated a target population based on the Community Health Needs Assessment, 11.4% of all Dallas County residents have diabetes, this equates to almost 275,000 individuals in the

[229] RHP 9 Community Health Needs Assessment

county. Literature shows that diabetes is more prevalent in the underserved community[230]. 19.6% of Dallas County has Asthma, which equates to 473,000 people. CHF accounts for about 200 deaths per 100,000 individuals in Dallas County. These statistics do not take into consideration any intersection of CHF, Asthma and Diabetes which makes individuals more complex and high risk. [231] Our project will serve approximately 688 new patients of this population.

Rationale

We selected this project option because of the prevalence of chronic disease in the underserved population. Through co-locating primary care, behavioral health and chronic disease management services, we can improve clinical outcomes. By increasing the availability of chronic care services and utilizing a team based approach, more patients can receive focused attention for their complex needs and learn to self-manage their illnesses in an effective way. We have demonstrated statistically significant reductions in mean HbA1c measures with a CHW model currently embedded in Baylor Clinics[232]. Thus expanding the educational services to serve more diabetes patients, and beginning to serve CHF and Asthma/COPD patients is a logical next step in improving the care of the population. The Community Health Needs Assessment identified the top 5 most prevalent conditions as: stroke, diabetes, CHF, failing kidneys and AMI. This project addresses 2 of these illnesses directly and 2 indirectly, it aligns exactly with the needs of the Region and the challenges that have been identified.[233]

Project Components

We will engage in continuous quality improvement activities throughout the duration of the project such as: 1) identifying key challenges with the expansion of this project, 2) determine opportunities to scale all or part of the project- depending on available resources and financial constraints, 3) find ways to continuously integrate the chronic disease management program into the care team as much as possible.

Reasons for selecting outcome measures

The Chronic Care Management metrics and milestones we have chosen focus on finding the appropriate model that would be effective in Dallas County that also addresses multiple chronic illnesses. Based on the complexities of the underserved population, we structured our metrics to focus on increasing access, awareness and education for individuals in the region and in the latter years including metrics around increased compliance to recommended clinical protocols. We believe it will take time for patients to understand and epitomize good self-management behaviors and it will also take times to see marked clinical outcome improvements. We do anticipate some clinical improvement for those patients that have been engaged in the chronic care management program for an extended period of time. We have not historically completed

[230] RHP 9 Community Health Needs Assessment

[231] Healthy People North Texas: http://www.healthyntexas.org

[232] Walton, J, Snead, C. et.al. Reducing diabetes disparities through implementation of a community health worker led diabetes self-management education program. Journal of Family and Community Health. 2012: 35(2): 161-71.

[233] RHP 9 Community Health Needs Assessment

programs for CHF and Asthma/COPD and will use this opportunity to create a continuous improvement environment where these programs can be refined and modified as we gather more experience.

Unique community need identification number the project addresses: CN.8 Chronic Disease

How the project significantly enhances an existing delivery system reform initiative

We currently do not receive any federal funding for chronic disease education and providing services for CHF and Asthma/COPD are new to the Baylor Clinic. This project coincides with the need to focus on chronic illnesses, as they are the main drivers of health care costs in the US. Diabetes alone costs the US almost $174 billion dollars a year. [234]

Related Category 3 Outcome Measures

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

Outcome Measure #1: IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (**Standalone measure**). In Dallas County, more than 11.4% of the population has a diagnosis of Diabetes with more than 32% of the population classified as obese and at risk for developing Diabetes[235]. Traditionally, the underserved population does not have access to the necessary medications, education and supplies to manage their diabetes, thus many times patients go undiagnosed or have poor glucose control. This project would facilitate timely and appropriate care for those with diabetes and ensure that regular labs and point of care testing is completed to monitor results and make appropriate interventions. We expect that at least 5-7% of patients that are seen regularly in a Baylor Clinic will have improved HbA1c levels Bodenheimer, et al., found that patient self-management of chronic disease conditions, such as diabetes, that was co-located in a primary care setting led to significant improvement in HbA1c control in patients[236]. A recent of edition of Managed Care found that patients with an HbA1c > 9 had on average almost $5000 worth of hospitalization costs, while those with an HbA1c of < 7 had about $2700 in hospitalization costs[237]. Focusing efforts on increasing improvement of good glycemic control will result diminishing in other co-morbid conditions and improve complication rates for these patients. We expect that at least 5-7% of patients that are seen regularly in a Baylor Clinic will have improved HbA1c levels.

Outcome Measure #2: T-1.11 Diabetes care: BP control (<140/80mm Hg) – NQF 0061 (**Standalone measure**). At Baylor Health Care System, blood pressure control and management

[234] http://www.diabetes.org/diabetes-basics/diabetes-statistics/

[235] RHP 9 Community Health Needs Assessment

[236] Bodenheimer, T., Lorig, K.., Holman, H., Grumbach, K. Patient Self-management of Chronic Disease in Primary Care *JAMA* (May 15, 2008).

[237] MenzinJ, Korn, J, Cohen, J, et.al Relationship between glycemic control and diabetes related hospital costs in patients with type 1 or type 1 diabetes mellitus. J Manag Care Pharm. 2010; 16(4):264-275.

is a required part of the diabetes care in order to avoid other co-morbid conditions such as heart disease and stroke. A 2010 study in the New England Journal of Medicine by Cushman, et. al showed that better and less severe health outcomes related to cardiovascular episodes and stroke were achieved with tight blood pressure control in diabetic patients[238]. Events that would be fatal with higher blood pressure became nonfatal under better blood pressure control in these studies completed. As part of an outpatient, clinic based protocol, blood pressure control can be achieved in patients who will come to the Baylor Clinic. Again, similar to HbA1c, we expect modest improvement in BP in years DY4 andDY5 contingent upon patient participation in the clinic and chronic disease program. Our primary goal will be to have patients come in for basic services and chronic disease education.

Outcome Measure #3: IT-1.13 Diabetes care Foot exam- NQF 0056 (**Non- standalone measure**).An innovative part of this project is that the educators (CHWs and RN Care Managers) will be able to conduct diabetic foot exams as part of their education session with their patients. This will increase the rate of screening and allow these providers to identify issues such as ulcers and nerve issues earlier and more often. Foot exams are a low cost, highly effective way to avoid costly interventions such as wound care and management, amputations,

Relationship to other Projects

121776204.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
This chronic care management project is related because: 1) services will be co-located and 2) the chronic care team will be integrated with the primary care team to facilitate complete care and efficiency for the patient.
121776204.2.2- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment
The project involving developing care management functions to integrate primary and behavioral health needs of individuals is related to this project of chronic care management because often times patients have co-occurring chronic disease and mental health issues which require attention. These programs can cross-refer depending on the patient's needs.

Related Category 4 Population-focused improvements
RD-1.1, RD-1.2, RD-1.4, RD-1.5, RD-2.1, RD-2.2, RD-2.4, RD-2.5, RD-2.7, RD-3.1, RD-3.2, RD-3.3, RD-3.4, RD-3.5, RD-3.6, RD-3.8, RD-3.10, RD-3.11, RD-3.12, RD-3.13, RD-3.14, RD-3.15, RD-3.24, RD-3.25, RD-3.26, RD-3.31

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Performing Provider	Unique Project	Project Option
Baylor University Medical Center	139485012.2.2	Expand Chronic Care Management Model – Diabetes (HbA1c poor control, BP control, foot exam)
Baylor Medical Center at Garland	121790303.2.2	
Trinity Medical Center (Baylor-Carrollton)	195018001.2.1	

[238] Cushman WC, Evans, GW, et al. Effects of intensive blood pressure control in type 2 diabetes mellitus. N Engl J Med. 2010. Apr 29; 362(17): 1575-85

Children's Medical Center	138910807.1.3	Implement pediatric disease registry – asthma
Denton County HHS	13660803.2.1	Implement disease registry – diabetes
Methodist Charlton Medical Center	126679303.2.1	Expand Chronic Care Management Model – Diabetes (30-day readmission, Hba1c, BP control)
Methodist Dallas Medical Center	135032405.2.1	
Methodist Richardson Medical Center	209345201.2.1	
Parkland Health & Hospital System	127295703.1.3	Implement chronic care registry
Parkland Health &Hospital System	127295703.2.4	Chronic Care Management Model – Diabetes
Texas Health Presbyterian Hospital Denton	020967801.2.2	Expand Chronic Care Management Model: Diabetes
Texas Health Presbyterian Hospital Kaufman	094140302.2.2	
UTSW – Faculty Practice Plan	126686802.2.2	Expand Chronic Care Management Model –Diabetes

Plan for Learning Collaborative.

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same process and technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor Medical Center at Irving defined the population that will be directly impacted by the project as underserved patients who have Diabetes, Asthma, and/or CHF that are in need of education and treatment. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***3.*** We believe, patients will increase their ability to self-manage her illness(es) and maintain their health rather than relying on the physician or ED to manage her conditions. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***3.*** We believe, when a person is positively impacted, his propensity to understand his illness, share his knowledge with others and help spread health literacy increases. Patients learn to manage their illnesses and escalations themselves rather than relying on expensive resources such as the ED.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects

within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121776204.2.1	***2.2.2***	***PROJECT COMPONENTS: CQI***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Baylor Medical Center at Irving				***121776204***
Related Category 3 Outcome Measure(s):	*121776204.3.9* *121776204.3.10* *121776204.3.11*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%) (**Standalone measure**)* *Diabetes care: BP control (<140/80mm Hg) (**Standalone measure**)* *Diabetes care Foot exam- (**Non- standalone measure**)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Develop a comprehensive care management program Metric 1 [P-3.1]: Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and the Institute of Chronic Illness Care's Assessment Model may be utilized in program development. Baseline/Goal: Determine exact care model to be used for CHF, Diabetes and COPD/Asthma patients Data Source: Documentation of plan and report showing detailed plans for addressing chronic disease education program Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 154,939 **Milestone 2** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1 [P-9.1]: Increase the number of patients identified as	**Milestone 3** [P-2]: Train staff in Chronic Care Model, incl essential components of delivery system that supports high-quality clinical & chronic disease care Metric 1 [P-2.1]: Increase % staff trained Baseline/Goal: Train 100% of clinic staff on CCM Data Source: Documentation of in-service or signed proclamation Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 112,687 **Milestone 4** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1 [P-9.1]: Increase the number of patients identified as needing screening test, preventative tests, or other clinical services Baseline/Goal: Compare patients with at least (1) or more chronic diseases from CHF, Diabetes, Asthma/COPD that have uncontrolled clinical metrics over DY2 to determine prevalence of these chronic diseases at Baylor Clinic Data Source: E.H.R, Report		**Milestone 6** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric 1 [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: At least 473 unduplicated patients will be served by Chronic Care Management program over DY2 Data Source: E.H.R Metric 2 [I-21.4]: Improved compliance with recommended care regimens. Goal: 15% of patients in Chronic Care Management program (for at least 6 months) will have improved compliance with recommended regimens by the educators (non-physician regimens) Data Source: Patient survey, Educator Report /E.H.R	**Milestone 7** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. The following metrics are suggested for use with an innovative project option but are not required. Metric 1 [I-21.2] : Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: At least 688 unduplicated patients will be served by Chronic Care Management program over DY2 Data Source: E.H.R Metric 2 [I-21.4]: Improved compliance with recommended care regimens. Goal: 20% of patients in Chronic Care Management program (for at least 6 months) will have improved compliance with recommended regimens by the educators (non-physician regimens)

121776204.2.1	*2.2.2*	***PROJECT COMPONENTS: CQI***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Baylor Medical Center at Irving				***121776204***
Related Category 3 Outcome Measure(s):	*121776204.3.9* *121776204.3.10* *121776204.3.11*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%) (**Standalone measure**)* *Diabetes care: BP control (<140/80mm Hg) (**Standalone measure**)* *Diabetes care Foot exam- (**Non- standalone measure**)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
needing screening test, preventative tests, or other clinical services Baseline/Goal: Determine current baseline of Baylor Clinic patients with at least (1) or more chronic diseases from CHF, Diabetes, Asthma/COPD that have uncontrolled clinical metrics Data Source: E.H.R., Report documenting current patients in need of Chronic Care Management program Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 154,939	documenting DY3 patient needs Milestone 4 Estimated Incentive Payment: $ $ 112,687 **Milestone 5** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. <u>Metric 1</u> [I-21.2]: Documentation of increased number of unique patients served by innovative program. Goal: At least 246 unduplicated patients will be served by CCM program over DY2 Data Source: E.H.R <u>Metric 2</u> [I-21.4]: Improved compliance with recommended care regimens. Goal: 10% of patients in CCM program (for at least 6 months) will have improved compliance with recommended regimens by the educators (non-physician regimens) Data Source: Patient survey, Educator Report/E.H.R Milestone 5 Estimated Incentive Payment: $ $ 112,686		Milestone 6 Estimated Incentive Payment: $ 339,042	Data Source: Patient survey, Educator Report/E.H.R Milestone 7 Estimated Incentive Payment: $ 280,078

121776204.2.1	***2.2.2***	***PROJECT COMPONENTS: CQI***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Baylor Medical Center at Irving				***121776204***
Related Category 3 Outcome Measure(s):	*121776204.3.9* *121776204.3.10* *121776204.3.11*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%) (**Standalone measure**)* *Diabetes care: BP control (<140/80mm Hg) (**Standalone measure**)* *Diabetes care Foot exam- (**Non- standalone measure**)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $ 309,877	Year 3 Estimated Milestone Bundle Amount: $ 388,060		Year 4 Estimated Milestone Bundle Amount: $ 339,042	Year 5 Estimated Milestone Bundle Amount: $ 280,078
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 1,267,057				

Project Option 2.19.1 – Develop Care Management Function that integrates primary and behavioral health needs of individuals

RHP Project Identifier: 121776204.2.2
Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Provider: Located in the heart of the Dallas-Fort Worth Metroplex, Baylor Irving serves Irving, Las Colinas and the surrounding communities. The not-for-profit 296-bed hospital offers advanced treatment capabilities in cardiology, orthopedics, oncology, digestive disorders, diagnostic imaging, physical medicine and emergency care. Baylor Irving's service area represents a population of 546,000.

Intervention(s): This project will co-locate and integrate outpatient behavioral health services using an LCSW to provide counseling services. Screenings for depression, substance abuse and anxiety will also be an integral part of the program. This is a new project that has not been done before. It will serve the BH needs of the Uninsured/Medicaid population.

Need for the project: The RHP 9 Community Needs Health Assessment identified behavioral and mental health issues are a large unmet need in most counties within the region and also identified as the most difficult to access services in the Region. Behavioral Health issues are an identified impediment to clinical adherence and when addressed can create a material impact on clinical outcomes. Behavioral Health issues are especially prevalent in the underserved populations.

Target population: Underserved (Medicaid and uninsured) population in the Irving area with behavioral health issues.
Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide screening and interventions to 688 patients in the Irving area. Approximately 85-90% of these patients will be Medicaid/Uninsured.

Category 3 outcomes: Category 3 outcomes for this project were chosen because: 1) the ambulatory setting of the project and 2) historical trends /literature based metrics that had material impact on patients in a 2-3 year time period.

- IT-11.1: Improvement in Clinical Indicator in Identified Disparity Group: Improvement in Diabetes Metrics (HbA1c, LDL, BP) for disparate group of uninsured/Medicaid patients with an underlying BH issue. Our goal is to have 5% of patients in DY3 achieve improvement in Diabetes Metrics (HbA1c, LDL BP), 10% in DY4 and 15% in DY5.

- IT-11.3: Improve utilization rates of clinical preventive services in target population with identified disparity: Improve utilization of BH services for patients who have been screened/identifed and diagnosed with an underlying BH issue. Disparate population is

underserved population with BH issue. Our goal is to increase the patients who engage in BH treatment rates from 10% in DY3 to 20% in DY5.

Project Description

This project will co-locate and integrate behavioral health services into the outpatient primary care setting. The model that we aim to develop would consist of providing a LCSW to provide basic counseling services to address behavioral health needs such as: anxiety, depression, and substance abuse issues. The screening tools we plan to use are evidence based and will most likely include: PHQ2 or 9, GAD-7 and alcohol and substance abuse screeners. Additionally, the LCSW would have the support of a Community Health Worker (CHW) to help with the screening and referral processes. The training for the CHWs , LCSWs and model development would occur at the Diabetes Health and Wellness Institute (Baylor entity in South Dallas) where the competencies and expertise would be created. From there, this staff can be triaged to clinics and community locations to provide behavioral health services. The behavioral health program would require that the LCSW and CHW to work together with the primary care team to: 1) identify the patients who have behavioral health issues, 2) coordinate the patient's care and appointments to fit both the behavioral health and primary care appointment in the same visit and 3) help the primary care team to identify those patients whose behavioral health issues are impeding the management of their acute/chronic disease management models. We anticipate approximately 85-90% of patients in this program will be Uninsured/Medicaid.

Goals and Relationship to Regional Goals

The goals of this project are to increase the baseline of behavioral health services provided and screenings conducted to the underserved population in the Irving area received in an outpatient setting. By co-locating the behavioral health service with a patient's PCMH, we anticipate that compliance and adherence to attending behavioral health appointments will increase. Through increased screening, awareness and intervention, we also anticipate that behavioral health issues such as anxiety, depression and substance abuse will be proactively identified and addressed in order to allow the clinician and patient to focus on more acute/chronic illnesses that require protocol adherence. The derivative goal of this would also be to decrease ED visits related to behavioral health issues that are manageable in the outpatient setting. We believe by treating the underlying barriers associated with behavioral health, this will result in better health outcomes for this population. The RHP 9 Community Needs Health Assessment identified behavioral and mental health issues are a large unmet need in most counties within the region and also identified as the most difficult to access services in the Region. There were three regional priorities around behavioral health including integrating behavioral health with primary care and addressing behavioral health in other settings. More than 10% o f Dallas County residents "binge drink" and there are more than 10 deaths per 100,000 related to suicide[239]. Only 19% of patients receive behavioral health and primary care services in the same setting[240]. The most compelling statistic is that 100% of the

[239] Healthy People North Texas: http://www.healthyntexas.org

[240] RHP 9 Community Health Needs Assessment

10 most frequently admitted patients had a co-occurring behavioral health diagnosis. The aforementioned statistics make a strong and significant case that basic behavioral health services can achieve "quick wins" for this underserved population. This project is directly aligned with the Regional needs and is positioned to help facilitate care related to substance abuse, anxiety and depression[241].

Challenges

The challenges with behavioral health initiatives are that identification of patients and willingness of those patients to participate in a formal program do not coincide. There is a stigma associated with receiving counseling or behavioral health services which makes it difficult for providers to identify patients that have these underlying behavioral health issues and even more difficult for providers to get patients to come in for these types of appointments. In the community, patients do not see their behavioral health issues as a medical condition, thus the problems are often ignored and results in these patients using the ED for their acute behavioral health escalations. While this program would not focus on serious psychiatric issues such as schizophrenia or bipolar disorders, identifying depression or anxiety can have a significant impact on the patient's propensity to comply with medication and clinical recommendations/protocols. The way we plan to address the challenges mentioned above is through providing these services in a non-threatening way by individuals (CHWs/LCSWs) that come from the community they are serving. By using CHWs or LCSWs over physicians or other higher level providers, this should put the patient at ease. The program will also be presented in a counseling type environment rather than a psychiatric evaluation environment. Lastly, we will make behavioral health screenings a routine part of most primary care visits so that the assessments coincide with the patient's typical care.

5-year Expected Outcome for Provider and Patients

The 5 year expected outcome is that at least 20% of the total unduplicated patients (approximately 688 patients) will receive behavioral health services at the Baylor Clinic at Irving. By identifying underlying behavioral health issues, acute and chronic medical issues can be addressed and compliance/adherence to clinical protocols should increase as well.

Starting Point/Baseline

There is no baseline for this project because there are no initiatives for behavioral health that are offered or ever have been at the Baylor Clinic located on the Baylor Medical Center at Irving. This is a brand new program that will be administered to Clinic patients. We do know that the target population in the Dallas county area is over 200,000 underserved individuals who suffer from a mental illness. We calculated this number taking the uninsured population in Dallas County (872,000)[242] and a 2011 statistic taken from the Centers for Disease Control and Prevention that found 23% of uninsured patients suffer from a mental illness.[243]

[241] Healthy People North Texas: http://www.healthyntexas.org

[242] http://quickfacts.census.gov/qfd/states/48/48439.html

[243] CDC: http://www.cdc.gov

Rationale

The reasons for selecting this project option are because behavioral health was not only identified as a major regional need, but Baylor Clinics have the infrastructure to effectively manage these types of issues within its PCMH framework. Many of our patients have underlying behavioral health issues which the physicians simply do not have time to address during a typical primary care visit, this model would allow patients to receive personalized attention for their behavioral health specific issues and allow the physicians to spend time on managing clinical issues. We believe by implementing a behavioral health component as part of the PCMH we have established, that patients will have improved overall health outcomes and providers will have greater satisfaction because these services will be performed by individuals who have an expertise in managing behavioral health issues. Lastly, we believe adding a behavioral health component to our primary care team will allow for cross communication between providers to understand all of the complex needs that are prevalent in this particular population.

Project Components

This behavioral health project has many components, all of which are addressed below:

a) Conduct data matching to identify individuals with co-occurring disorders who are:
   - not receiving routine primary care-*Patients who enter in to the behavioral health program will be automatically part of a PCMH*
   - not receiving specialty care according to professionally accepted practice guidelines: *We will be tracking this metric as part of our specialty care project- 1.9.*
   - over-utilizing ER services based on analysis of comparative data on other populations: *This is a metric that we already track and will continue to do so*
   - over-utilizing crisis response services. *This particular factor may be difficult to gather data on and is not typically a data point we collect*
   - Becoming involved with the criminal justice system due to uncontrolled/unmanaged symptoms. *This factor may be difficult to gather data on - not typically collected*

b) Review chronic care management best practices such as Wagner's Chronic Care Model and select practices compatible with organizational readiness for adoption and implementation. *We plan to review the most effective models that address both chronic care and behavioral health to determine which model would easily address the intersection of both programs*

c) Identification of BH case managers and disease care managers to receive assignment of these individuals: *We plan on hiring LCSWs and CHWs to act as BH care managers*

d) Develop protocols for coordinating care; identify community resources and services available for supporting people with co-occurring disorders: As part of identifying which patients would be eligible and appropriate for this BH program, we will be developing

clinical protocols to identify patients and coordinate their care within the Baylor Clinic PCMH

e) Identify and implement specific disease management guidelines for high prevalence disorders, e.g. cardiovascular disease, diabetes, depression, asthma. *We plan to address this criteria through Chronic Care Management project (2.2.1- Expand Chronic Care Management Models)*

f) Train staff in protocols and guidelines. *All staff will be made aware of this program and be trained on scheduling and identifying patients who could be part of this BH program*

g) Develop registries to track client outcomes. We currently have a robust E.H.R in which we track other patient clinical metrics and measures, it would be redundant and inefficient to create a separate registry to track outcomes of this specific project. We intend to track outcomes in the current E.H.R.

h) Review the intervention(s) impact on quality of care and integration of care and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations. *As part of our monthly review of project status, this will be included as will review of other DSRIP projects the Baylor Clinic will be engaged in. We will focus on key challenges associated with expansion and determine how and if BH needs to be scaled to meet patient needs.*

Reasons for selecting outcome measures

The milestones and metrics chosen are focused on increasing volumes of patients seen. In order to be effective, patients will need to attend their appointments and be compliant with the recommended guidelines for their behavioral health issues and subsequent medical issues. In order to achieve the proposed metrics and milestones all of the other DSRIP projects will have to coordinate and synchronize in order to fulfill the metrics chosen. This will be advantageous to the Region, as it will create synergy and a complete plan of care for the patients in the target population. In the Planning Protocol, there were no options for Improvement Milestones that were directly applicable to this Behavioral Health program. Many of the metrics were focused on chronic disease, which we have an entire separate DSRIP project dedicated to. Thus, we created two customizable improvement milestones that focus on 1) increasing patient volumes (capturing eligible patients) and 2) improving rates of screening for anxiety, depression and substance abuse.

Specify the unique community need identification number the project addresses:

CN.5- Behavioral Health, CN.6-Behavioral Health and Primary Care

How the project significantly enhances an existing delivery system reform initiative

This project does not receive any federal funding and is a brand new initiative. There is currently no outpatient based behavioral health program offered to the underserved population at the Baylor Clinic at the Baylor Medical Center at Irving. This project will provide a

low cost, effective intervention to those patients with behavioral health needs in a setting that is manageable for providers to identify potential escalation points related to behavioral health issues.

Related Category 3 Outcome Measures

Category 3 metrics for this project were identified using literature only. Baylor has had no previous experience with a behavioral health program of this nature. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. We will establish project baselines during DY2.

Outcome Measure #1: IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (**Standalone measure**). We plan to measure the impact of diabetes management and control for patients who have enrolled in the proposed behavioral health program. A recent study conducted in early 2012, by Jeffery Johnson, et. al showed a direct correlation between diabetes and depression. They cited that depression is the most common co-morbid condition present in 15-30% of patients with Type 2 diabetes and less than 50% are recognized as having depression.[244] Depression is associated with poorer self care behaviors, decreased quality of life and substantially higher health care costs. Both diabetes and behavioral health issues are prevalent across the region, warranting measurement of the efficacy of a behavioral health program on chronic diseases.

Our Baylor Clinics currently track the Diabetes Percent of Opportunities Achieved (POA) for all patients with Diabetes. This is calculated by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population. POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in diabetes management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their diabetic patients than in the prior reporting period.

For an illustrative example: For Diabetes- there are 3 opportunities (i.e. metrics) per patient (1) LDL < 100 (2) A1c < 8 and (3) BP < 130/80 mmHg. The denominator would be # of patients x 3. So, for example, if there are 10 patients x 3 opportunities each = 30 opportunities to be achieved. If, in the course of the year, only 20 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 20/30=67%. To achieve a 10% improvement in POA, we would have to have completed at least 23/30 opportunities to get at 76% achievement.

[244] Johnson, JA, Sayah, FA, et.al. Controlled trial of a collaborative primary care team model for patients with diabetes and depression: rationale and design for a comprehensive evaluation. BMC Health Services Research. 2012, 12:358

However, adding behavioral health as a subset of measurement for this patient population may change the actual improvement that is attainable. Because this is a new program, we do not have any historical data on the actual Diabetes improvement for those patients who receive a behavioral health intervention. We only have literature which has shown improvement in Diabetes with interventions related to depression. Thus, the improvement targets we have listed for Category 3 may differ as we implement the program.

Outcome Measure #2: IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (**Non-standalone measure**). We plan to focus on the treatment component of this metric, defining treatment as those patients who engage in the behavioral health program. We anticipate that patients who enter our Baylor Clinic and are identified as individuals who would benefit from a behavioral health intervention will have improved treatment and utilization rates.
Numerator: patients who are a Baylor Clinic patient and engage in behavioral health program
Denominator: patients who are a Baylor Clinic patient, eligible for behavioral health services
The idea of this metric is that by engaging patients in behavioral health treatment/interventions that their subsequent medical care will also improve. Patients who engage are those who have had at least two behavioral health interventions/encounters in the past 12 months. Patients eligible for behavioral health entail those that have 1) been identified through the PHQ2/9, GAD-7 and Substance Abuse screening tools that are in need of intervention, 2) self- identified need or 3) provider/clinician identification of patient need for behavioral health counseling. This Outcome Measure differs from our customized Improvement Milestone I-X: Target Population Reached: Increase Number of patients enrolled in BH program because the Improvement Milestone is focused on increasing volumes of eligible patients. Outcome measure 11.3 takes this one step further to ensure that the patient actually engages in the behavioral health program. By qualifying "engage" as a minimum of two interventions/encounters in the last 12 months, this varies from the Improvement Milestone of just increasing volume.

Relationship to other Projects

121776204.2.2- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program. The Chronic Care Management Model project is related because if patients have a co-occurring behavioral health issue and chronic diseases, the services are co-located and patients can be referred into both programs if necessary

121776204.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
This behavioral health project is related to the expansion of primary care capacity project because 1) the services will be co-located and 2) the behavioral health team will be part of the overall primary care team; providing complete and efficient care for the patient.

Category 4 Population-focused improvements

RD-1.3, RD-1.7, RD-1.8, RD-1.1, RD-1.2, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.7, RD-3.36, RD-4.1, RD-4.2, RD-5

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Behavioral Health is pressing issue across the Region and will require collaboration and coordination between providers to manage these types of issues in a less costly, personalized setting. Our project differs from the two above because our focus is on counseling and screening. We will focus on disorders such as depression, anxiety and substance abuse. The plan is to continue learning collaborative initiatives through the Dallas-Fort Worth Hospital Council for the performing providers of RHP 9.

Plan for Learning Collaborative.

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we priced our projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor Medical Center at Irving defined the population that will be directly impacted by the project as the underserved PCMH Baylor Clinic patients with an underlying behavioral health issue(s). We used the pricing matrix developed by Regional providers to determine the value for each positive outcome. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***3.*** We believe this because, when a person is impacted, their compliance and adherence to clinical protocols increases, their satisfaction increases and self-management of their illnesses increases. To determine the value to the community, we concluded that, on a 1-5 scale, the value of this project is ***4.*** We believe when a person is positively impacted, their productivity in the community increases as mentioned in the Community Health Needs Assessment where 25% of the population reported lost work days due to a mental health issue. In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an

econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121776204.2.2	*2.19.1*	*2.19.1.(A-H)*	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS-*** *BEHAVIORAL HEALTH COUNSELING, SCREENING AND TREATMENT*	
Baylor Medical Center at Irving				*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.12* *121776204.3.13*	*3.IT-11.1* *3.IT-11.3*	*- Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider – Diabetes Improvement (**Standalone measure**)* *- Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity- BH Treatment Rate Improvement (**Non-standalone measure**)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Data matching is performed identifying service utilization patterns of people with co-occurring disorders and analysis conducted to identify over and under-utilization patterns Metric 1 [P-4.1]: Data analysis report produced. Baseline/Goal: Determine number of patients with dual diagnosis- either self- identified or through previous medical history- to understand actual need in community Data Source: E.H.R/patient survey Milestone 1 Estimated Incentive Payment: $ 88,685 **Milestone 2** [P-5]: BH case managers and disease care managers are identified. Metric 1 [P-5.1]: Number of staff identified with the capacity to support the targeted population. Baseline/Goal: Hire 0.5 FTE of support staff (MA/POR) to handle case management of BH patients	**Milestone 4 [P-4]**: Data matching is performed identifying service utilization patterns of people with co-occurring disorders and analysis conducted to identify over and under-utilization patterns Metric 1 [P-4.1]: Data analysis report produced. Baseline/Goal: Define number of current patients with dual diagnosis and compare to DY 2 data collected Data Source: E.H.R/patient survey Milestone 4 Estimated Incentive Payment: $72,563 **Milestone 5** [P-6]: Care coordination protocols are developed. Metric 1 [P-6.1]: Written protocols are easily available to staff. Baseline/Goal: Educate 100% of clinic staff on BH protocols/standing order Data Source: Documentation of education completed through in-service sheets or signed documentation by staff	**Milestone 8** [I-X]: Patient enrollment in program Metric 1 [I-X.1]: Target Population Reached: Increase Number of patients enrolled in BH program Goal: **473** unduplicated patients will be identified and seen for a BH issue over DY2 Data Source: E.H.R Milestone 8 Estimated Incentive Payment: $ 145,549 **Milestone 9** [I-X]: Improve screening rates for depression, anxiety and substance abuse Metric 1 [I-X.1]: Short Term Outcomes: Improve % of patients screened with at least one BH tool Goal: 20% of all patients will be screened with PHQ2/9 or GAD-7 or Substance Abuse screening Data Source: E.H.R (% is the same to account for attrition in patient population) Milestone 9 Estimated Incentive Payment: $145,548	**Milestone 10** [I-26]: [I-X]: Patient enrollment in program Metric 1 [I-X.1]: Target Population Reached: Increase Number of patients enrolled in BH program Goal:**688** unduplicated patients will be identified and seen for a BH issue over DY2 Data Source: E.H.R Milestone 10 Estimated Incentive Payment: $ 120,236 **Milestone 11** [I-X]: Improve screening rates for depression, anxiety and substance abuse Metric 1 [I-X.1]: Short Term Outcomes: Improve % of patients screened with at least one BH tool Goal: 25% of all patients will be screened with PHQ2/9 or GAD-7 or Substance Abuse screening Data Source: E.H.R (% is the same to account for attrition in patient population) Milestone 11 Estimated Incentive Payment: $ 120,236

121776204.2.2	*2.19.1*	*2.19.1.(A-H)*	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS-*** *BEHAVIORAL HEALTH COUNSELING, SCREENING AND TREATMENT*	
Baylor Medical Center at Irving				*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.12* *121776204.3.13*	*3.IT-11.1* *3.IT-11.3*	*- Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider – Diabetes Improvement (**Standalone measure**)* *- Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity- BH Treatment Rate Improvement (**Non-standalone measure**)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Documentation of hired staff Milestone 2 Estimated Incentive Payment *(maximum amount):* $88,685 **Milestone 3** [P-6]: Care coordination protocols are developed. Metric 1 [P-6.1]: Written protocols are easily available to staff. Baseline/Goal: Develop protocols for identifying BH patients and protocols for making appointments. Ensure that executive physician committee signs off on protocols for LCSW. Data Source: Documentation of clinical protocols and processes Milestone 3 Estimated Incentive Payment *(maximum amount):* $88,686	Milestone 5 Estimated Incentive Payment: $72,563 **Milestone 6** [I-X]: Patient enrollment in program Metric 1 [I-X.1]: Target Population Reached: Increase Number of patients enrolled in BH program Goal: 246 unduplicated patients will be identified/seen for a BH issue over DY2 Data Source: E.H.R Milestone 6 Estimated Incentive Payment: $72,563 **Milestone 7** [I-X]: Improve screening rates for depression, anxiety and substance abuse Metric 1 [I-X.1]: Short Term Outcomes: Improve % of patients screened with at least one BH tool Goal: 15% of all clinic patients will be screened with PHQ2/9 or GAD-7 or Substance Abuse screening Data Source: E.H.R		

121776204.2.2	***2.19.1***	***2.19.1.(A-H)***	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS-*** *BEHAVIORAL HEALTH COUNSELING, SCREENING AND TREATMENT*	
Baylor Medical Center at Irving				*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.12* *121776204.3.13*	*3.IT-11.1* *3.IT-11.3*	*- Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider – Diabetes Improvement (**Standalone measure**)* *- Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity- BH Treatment Rate Improvement (**Non-standalone measure**)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 7 Estimated Incentive Payment: $72,564		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 266,056	Year 3 Estimated Milestone Bundle Amount: $290,253	Year 4 Estimated Milestone Bundle Amount: $291,097	Year 5 Estimated Milestone Bundle Amount: $240,471
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,087,877			

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program - Care Connect

RHP Project Identifier: 121776204.2.3
Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Provider: Located in the heart of the Dallas-Fort Worth Metroplex, Baylor Irving serves Irving, Las Colinas and the surrounding communities. The not-for-profit 296-bed hospital offers advanced treatment capabilities in cardiology, orthopedics, oncology, digestive disorders, diagnostic imaging, physical medicine and emergency care. Baylor Irving's service area represents a population of 546,000.

Intervention(s): This project will identify and connect underserved patients in the hospital to a PCP/PCMH, create a multi-disciplinary care plan for frequently admitted patients and provide comprehensive follow up calls to patients to ensure they have an appointment and transportation to get to it. This project will be new to Baylor Irving, utilizing the technique and infrastructure from Baylor University Medical Center and Baylor Medical Center at Garland.

Need for the project: Connecting patients to a PCP/PCMH will reduce ED utilization and provide outpatient services for complex patients. Overutilization of the ED was identified as a Regional issue.

Target population: The 872,000 uninsured and Medicaid population in Dallas County without a PCP/PCMH who come to the ED. Approximately 85% of new patients enrolled in this program will be Medicaid/Uninsured.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide access to an anticipated 3360 new patients from the community.

Category 3 outcomes: Category 3 outcomes for this project are from 2 different domains the true impact of this project is through ED appropriate utilization and cost savings. Both are priorities for the Region, which is why we felt we should show improvement in both areas.

- IT-5.1: Improved Cost Savings. Our goal is to increase cost savings of healthcare utilization (total cost of care in one year) of patients who have been connected to a PCP/PCMH appointment from 15% in DY3 to 25% in DY5. .
- IT-6.1: ED Appropriate Utilization.Our goal is to decrease all ED visits (including ACSC) from 25% in DY3 to 35% in DY5 and targeted conditions ED utilization (CHF, Diabetes, ESRD, CVD/Hypertension, BH/SA, COPD, Asthma) from 10% in DY3 to 20% in DY5. We will be excluding pediatric emergency visits as part of this metric measurement because Baylor Medical Center at Irving ED does not see a large volume of pediatric patients.

Project Description

This project aims to create a fluid care navigation program located at Baylor Medical Center at Irving Emergency Department for patients (including Medicaid/Uninsured) who are identified (or proclaim) to not have a primary care physician and/or patient centered medical home to address their post-acute care needs. Approximately 85% of new patients enrolled in this program will be Medicaid/Uninsured. By having staff physically located in these locations, patients can receive real time assistance in finding a provider and ensuring they are connected with the appropriate resources they would require once discharged home. We will include staff coverage on the weekends as well to ensure that patients are able to be seen and connected to resources 7 days/week. Additionally, in order to close the loop, staff will follow-up with patients to make sure they have an appointment and that they attend their appointment. The staff will also be responsible for ensuring that other barriers such as transportation are addressed and patients are able to attend their follow-up visits. The Care Connect staff will receive e-mail notifications any time a patient revisits the hospital, at this time staff will proactively visit with the patient to ensure the patient is able to access their PCP/PCMH appointment and/or recommended community resource(s). Care plans will be developed for patients with high hospital utilization (especially patients with frequent emergency department visits) and complex needs. Care plans will include involvement with Social Work Supervisor, Hospital Medical Director and other hospital staff. Patients with care plans will be contacted as often as needed to ensure continuity of the care plan.

Goals and Relationship to Regional Goals

The goals for this project are: 1) to connect a greater number of patients to a PCP/PCMH in the Irving community, 2) ensure the patients have the resources they need to care for themselves post discharge, 3) keep patients out of the ED and 4) create a care plan for high risk patients which ensures that the patient is receiving the follow-up care they need and are identified by staff when they readmit to the hospital

One of the major goals for the region is to reduce ED utilization and readmissions. This project focuses on and emphasizes both of these components. The entire impetus of the project is focused on Care Coordination and ensuring that patients are triaged to appropriate community and outpatient based resources. This is a strategy to decrease overall spending on health care in the region and help more patients connect to the essential primary care needed to maintain their health.

Challenges

Challenges with the underserved population almost always route back to the lack of continuity of care across the continuum. Because of their financial, time and resource constraints, this population often find a temporary fix to their health issue and once discharged from the hospital do not receive the care they need to stay healthy. If a patient is given an appointment

post discharge, they may have issues with transportation and other barriers that impede their access to care. Typically there is no follow-up to ensure the patient knows when their appointment is and if they actually went. This program aims to address these issues by identifying patients who do not have a PCP/PCMH, finding one for them, ensuring they have the resources they need to keep their appointment and then following up with the patient.

5-year Expected Outcome for Provider and Patients

The 5-year expected outcomes for this project include: 1) a minimum of 3360 patients connected to a PCP, PCMH or community resource, 2) 35% of these patients will have confirmed appointments within 14 days post-discharge. We expect that there will be fewer ED visits and readmissions for this population that was connected through this program and will experience overall improved health outcomes due to receiving appropriate and adequate post-acute care.

Starting Point/Baseline

The baseline for this project at Baylor Medical Center at Irving is 0. This program will be brand new to the hospital. Based on recent performance at Baylor Medical Center at Garland for the same program, about 849 patients were served by the program from November 2011 to July 2012. We will have to establish the baseline of this project and determine the potential number of patients that would benefit from this program at Baylor Irving in DY2 and DY3. We anticipate that the targeted population for the entire region is approximately 260,000 patients. This is calculated by taking the average rate of patients who are uninsured that do not have a PCMH/PCP (30%) multiplied by the total number of uninsured in Dallas (36% of the population).[245]

Rationale

We selected this project because it is a low cost, highly effective way to help promote the continuity of care for the underserved population. Utilizing CHWs and social work as the main staff involved in this project, these individuals are connected to the community and understand their complex needs. This project helps patients that do not have a PCP/PCMH connect to one and then also offers the continuous improvement piece that is often missing in these types of initiatives. We selected this project for Baylor Medical Center at Irving because we have seen demonstrated results in the time the project has been implemented at Baylor Medical Center at Garland and expect similar results at Baylor Medical Center at Irving. The program has reduced readmissions and lowered ED utilization. The other attractive component this project are the multidisciplinary care plans that will be developed for the highest risk patients to identify these individuals and hone in on triggers that cause them to (re)admit. We believe that this intervention is an effective way for staff to be involved with the patient at a grassroots level and allow patients to feel that they have someone responsible for their ongoing care and navigation needs.

[245] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/48439.html

Project Components
This project has multiple components from the protocol, all of which are listed below:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency: *This is a core part of our program we will be focusing on all ED patients that are identified to not have a PCP/PCMH. Our Care Plans are developed for patients who are frequent ED utilizers as well. Lastly, our CHWs that we will be hiring come directly from the communities they serve so they understand the challenges/issues with the patients that come from that community.*
b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators. *This project will primarily be using CHWs and Social Workers to help navigate patients.*
c) Connect patients to primary and preventive care. *The impetus of this program is focused on connecting patients to PCP/PCMH*
d) Increase access to care management and/or chronic care management, including education in chronic disease self-management. *Through connecting patients to a Baylor Clinic PCMH, these services for chronic care management will also be addressed.*
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. *This project will be part of an overall Baylor initiative that will be analyzing and evaluating the progress and challenges/barriers for all DSRIP projects. We will focus on identifying key challenges associated with the expansion and opportunities to scale the project where appropriate.*

Reasons for selecting outcome measures
The milestones and metrics that we chose are directly related to two of the goals identified by the region: 1) need for more care coordination and 2) overuse of ED services. The metrics we have in place increase the number of the target population served over the Waiver period and emphasize the connection rate to a PCP/PCMH. In addition, we have added a metric that creates regular reports that show comparative analyses year over year of the program. We believe by running detailed reports on what services were provided and how these coincide with the needs of the community, will allow for maximum effectiveness and positive outcomes of the project. These metrics directly impact the health and well-being of the patients served and ensure continuity in their care.

Unique community need identification number the project addresses
CN.12- ED Utilization and Readmissions

How the project significantly enhances an existing delivery system reform initiative
This project does not receive any federal funds and is a new initiative. It is focused on reducing high cost utilization of the ED setting and connects patients with a PCP/PCMH to avoid subsequent ED visits. This is a low cost, highly effective way to keep patients in appropriate care settings to manage their needs.

Related Category 3 Outcome Measures
The Standalone and Non-standalone metrics come from 2 different domains because the true impact of this project is through ED appropriate utilization and cost savings. Both are priorities for the Region, which is why we felt we should show improvement in both areas.

Outcome Measure #1: IT-9.2 ED appropriate utilization (**Standalone measure**). According to the Community Health Needs Assessment of Region 9, 68% of the ED visits in the region were for non-emergent situations that could have been handled in the primary care/outpatient settings. This metric is at the heart of the care navigation project we are proposing and will have a direct impact on patients in Dallas County utilizing the ED at a decreased rate. This project uses the popular concept created by Dr. Atul Gawande, referred to as "hot spotting" indicating a focus on finding the high risk/high utilization rates of the ED and determining the root cause for these visits, and then working to remedy those issues. Issues such as transportation, navigation of community and appropriate resources are just two examples that can lead to more effective use of the ED[246].

Outcome Measure #2: IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (**Non- standalone measure).** Financial constraints are a main concern for the Region in being able to provide high quality care to the underserved population. Cost savings and effectiveness are a key part of the overall Waiver and require providers to be good stewards of their resources. This metric is appropriate because it emphasizes appropriate utilization of resources and reinforces the concept of cost effectiveness. We plan to measure the cost effectiveness and cost utilization of this project. According to the Texas Medical Association, the cost of treating a condition that could be treated in the doctor's office for $56.21 (including lab and x-ray) costs $193.92 in the Emergency room[247]. This cost differential multiplied by the 443,000 uninsured in Dallas County creates a significant cost to the county and Region. On a more global level, AHRQ found that the average cost in 2006 for an uninsured patient stay in the hospital cost about $19,400. There is definite room for opportunity to produce cost savings for this population.[248]

Relationship to other Projects
121776204.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
The navigation program is located in the hospital and will facilitate the connection of patients to the Baylor Clinic that are identified by the staff to not have a PCP/PCMH.

[246] Gawande, A. The hot spotters: can we lower medical costs by giving the neediest patients better care? The New Yorker. (2011).
[247] Texas Medical Association: http://www.texmed.org
[248] AHRQ: http://www.ahrq.gov

Related Category 4 Population-focused improvements
RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.7, RD-1.8, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7, RD-4.1, RD-4.2, RD-5.1

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives
Care Coordination models require an initial connection but also require resources to triage patients to. Once a patient is identified to need a PCP/PCMH or another community resource, it becomes the Region's responsibility to ensure there are outlets for these patients to receive the care they need. Care Navigation programs serve the patients located in the specific EDs/inpatient units of the performing providers and thus do not duplicate patients on a per visit basis. While our geographies overlap, these programs are localized to individual hospitals. The projects in RHP 9 to enhance patient navigation programs include the following:

Performing Provider	Unique Project Number
Baylor Medical Center at Garland	121790303.2.3
Baylor University Medical Center	139485012.2.3
Children's Medical Center	138910807.2.3
Medical Center of Lewisville (HCA)	094192402.2.3
Methodist Charlton Medical Center	126679303.2.2
Methodist Dallas Medical Center	135032405.2.1
Methodist Richardson Medical Center	209345201.2.1
Parkland Health & Hospital System	127295703.2.7
Texas Health Presbyterian – Denton	020967801.2.1
Texas Health Presbyterian – Kaufman	094140302.2.1
University of Texas Southwestern – Faculty	126686802.2.4
University of Texas Southwestern – Hospital	175287501.2.1

Learning Collaborative. We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation
Baylor Health Care System spans over 3 Regional Healthcare Partnerships. In order to be consistent in our valuation methodology, we have used the same process and technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced our projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. ***Baylor Medical Center at Irving*** has computed the value

of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor Medical Center at Irving defined the population that will be directly impacted by the project as the underserved/uninsured patients that do not have a PCP/PCMH that present in our ***Baylor Medical Center at Irving*** *ED or inpatient units.* We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3. We believe this to be the correct number because, when a person is connected to community and primary care resources, they can find ways to manage their illnesses on a daily basis and have a contact for their care needs. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a *4.* We believe this to be the correct number because, when a person is positively impacted, their ED utilization decreases, community resource burdens are relieved and a greater number of people have a PCMH.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121776204.2.3	***2.9.1***	***2.9.1 (A-E)***	***ESTABLISH/EXPAND A CARE NAVIGATION PROGRAM - CARE CONNECT***
Baylor Medical Center at Irving			*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.14* *121776204.3.15*	*3.IT-5.1* *3.IT-9.2*	*Improved cost savings: Demonstrate cost savings in care delivery* ***(Non-Standalone)*** *ED appropriate utilization (****Standalone measure****)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: 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: Hire appropriate staff- 2 FTEs Data Source: HR Documentation Metric 2 [P-2.2]: Number of unique patients enrolled in the patient navigation program; Baseline/Goal: Establish baseline of patients seen in DY2 Data Source: EHR/Navig. database Metric 3 [P-2.3]: Frequency of contact with navigators for high risk patients Baseline/Goal: Track frequency of patient contact with navigator while	**Milestone 3** [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. Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided Baseline/Goal: Provide completed report to compare types of navigation offered in DY2 v. DY3 Data Source: E.H.R/Navigation notes and database Milestone 3 Estimated Incentive Payment: $145,127 **Milestone 4** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric 1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care referrals	Milestone 5 [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric 1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care referrals to at least 40% of patients indentified by care navigation program Data Source: E.H.R./Patient Navigation program database Metric 2 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Identify at least 1200 patients Data Source: E.H.R./Patient Navigation program database Milestone 5 Estimated Incentive Payment: $ 291,097	Milestone 6 [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care referrals to at least 50% of patients identified by care navigation program Data Source: E.H.R./Patient Navigation program database Metric 2 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Identify at least 1440 patients Data Source: E.H.R./Patient Navigation program database Milestone 6 Estimated Incentive Payment: $ 240,471

121776204.2.3	***2.9.1***	***2.9.1 (A-E)***	***ESTABLISH/EXPAND A CARE NAVIGATION PROGRAM -*** *CARE CONNECT*	
Baylor Medical Center at Irving				*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.14* *121776204.3.15*	*3.IT-5.1* *3.IT-9.2*	*Improved cost savings: Demonstrate cost savings in care delivery* ***(Non-Standalone)*** *ED appropriate utilization (****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)**
in ED setting Data Source: E.H.R./Patient Navigation program database Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 133,028 **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. <u>Metric 1</u> [P-5.1]: Collect and report on all the types of patient navigator services provided Baseline/Goal: Create report format and educate navigators about data points to be collected Data Source: Documentation of report created Milestone 2 Estimated Incentive Payment *(maximum amount):* $133,028	to at least 30% of patients identified by the navigation program Data Source: E.H.R./Patient Navigation program database <u>Metric 2</u> [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Identify at least **720** patients Data Source: E.H.R./Patient Navigation program database Milestone 4 Estimated Incentive Payment: $145,126		
Year 2 Estimated Milestone Bundle Amount: $ 266,056	Year 3 Estimated Milestone Bundle Amount: $ 290,253	Year 4 Estimated Milestone Bundle Amount: $291,097	Year 5 Estimated Milestone Bundle Amount: $240,471
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 1,087,877			

Project Option 2.12.2 – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)

RHP Project Identifier: 121776204.2.4 – Pass 2
Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Provider: Located in the heart of the Dallas-Fort Worth Metroplex, Baylor Irving serves Irving, Las Colinas and the surrounding communities. The not-for-profit 296-bed hospital offers advanced treatment capabilities in cardiology, orthopedics, oncology, digestive disorders, diagnostic imaging, physical medicine and emergency care. Baylor Irving's service area represents a population of 546,000.

Intervention(s): This project will provide in-home visits to the highest risk uninsured and Medicaid patients. Risk is defined by patient propensity of complications, (re)admissions, downstream healthcare utilization and costs within the parameters of socioeconomic and clinical risk indicators. The team will be led by an APRN overseen by a Medical Director and augmented with a Social Worker, LVN and Care Coordinator who will have overall oversight and responsibility of continuity of care for the patients in the program. Services such as examinations and clinical decision making to changing urinary catheters, labs, vaccinations and medication reconciliation, management and education will be available in the patient's home. This project is a new initiative at Baylor Medical Center at Irving.

Need for the project: High risk and complex patients that need intensive management will receive care in their homes to address acute and chronic needs. This should facilitate fewer visits to the ED, greater compliance to clinical protocols and regimens and create improved quality outcomes.

Target population: The top 5% highest risk patients of the 872,000 uninsured and Medicaid population in Dallas County that have at least one of the following characteristics: homebound, disabled, multiple chronic diseases, polypharmacy or any other medical or social conditions limiting the patients' ability to access care in an ambulatory care setting.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide care to 50 high risk patients.

Category 3 outcomes: Category 3 outcomes for this project focus on identifying and improving impediments to patient care in order to increase compliance and better outcomes.

- IT-10.1: Quality of Life. Our goal is to increase the mean score (from time of enrollment to current survey) on QOL assessments by 7% by DY5 for patients in the program for 6+ months.

- IT-10.2: Activities of Daily Living. Our goal is to increase the mean score (from time of enrollment to current survey) on ADL assessments by 7% by DY5 for patients in the program for at least 6 months.

Project Description

The Vulnerable Patient Network (VPN) program provides home visits to the highest risk (clinically, economically and socially) and vulnerable Medicaid and uninsured patients. Using a combination of the Hot Spotting model developed by Dr. Jeffery Brenner of the Camden Coalition of Healthcare Providers[249] and a validated risk stratification tool, we will stratify and identify the top 5% of high risk patients in the Medicaid and Uninsured population. Qualifiers for enrollment in this program include patient characteristics that include but are not limited to: homebound, disabled, multiple chronic diseases, polypharmacy or any other medical or social conditions limiting the patients' ability to access care in an ambulatory care setting. A multidisciplinary team comprised of an advanced nurse practitioner (APRN) and LVN to see patients in the home and provide acute, primary and chronic care. In addition, social workers will be part of the team to address barriers to care and any social issues. Care Coordinators will also be part of this team to facilitate coordination and continuity of care for patients and have high level oversight for patients; bringing together the necessary components of care for these complex patients. Lastly, a Medical Director will have management over the entire project. A full spectrum of services will be available in the patient home ranging from examinations and clinical decision making to changing urinary catheters, labs, vaccinations and medication reconciliation, management and education.

Goals and Relationship to Regional Goals

The goals for this project are: 1) Increase patients who receive primary care, 2) Overcome access issues for high risk patients, 3) Address acute care issues in the patient's home rather than the Emergency Department, 4) Increase patient compliance and adherence to regimens, 5) Decrease barriers to care around receiving medications and overall care, 6) Increase contact rate with provider for high risk patients and 7) Increase medication reconciliation frequency.

Two of the goals for the region include increasing healthcare capacity and decreasing ED utilization and readmissions. This project increases access to care for those high risk patients who are unable or unwilling to be seen in primary care office. It creates additional points of care for patients to receive care and improve compliance and clinical outcomes. Patients who have multiple chronic diseases and unable to go to appointments can have their conditions proactively managed in their homes. Together long term disease management and avoidance

[249] Gawande, A. "The hot spotters." *The New Yorker*, January 24, 2011.

of exacerbations lead to better clinical outcomes, lower ED utilization, lower costs and better overall patient health. According to the Community Needs Assessment, the conditions with the highest ED visit volumes for the Medicaid and uninsured population were: diabetes, CHF and stroke. With proper and consistent management, these conditions are manageable.[250] The top 10 utilizers of health care services in the region accumulated $26 million in costs.[251] These patients would be candidates for this Home Visit program, identifying them through the "hot spotting" methodology[252] and proactively managing their conditions. This program will help to improve outcomes of chronic diseases and related complications by proactively managing the patient in a setting that is convenient and comfortable for them, hopefully increasing compliance to treatment protocols and medication adherence.

Challenges

High risk (clinical and socioeconomic) uninsured and underinsured patients often have multiple co-morbidities, issues with access and lack of resources to care for themselves. These patients, due to financial and other constraints cannot afford medications, transportation to appointments and may be physically incapable of leaving their homes to receive care. These are the patients that end up having their clinical conditions escalate and end up in the Emergency Department because the lack of adequate and timely primary care. This program would remove barriers to access by providing a full range of clinical and social services high risk patients need in their homes. This also allows the care team to physically survey the patient's living conditions and find inhibitors to help the patient overcome these issues to better care of themselves.

5-year Expected Outcome for Provider and Patients

The 5-year expected outcomes for this project include: 1) provide home care to a minimum of 50 patients, 2) improve mean quality of life scores by a 7% over baseline for patients enrolled in VPN for at least 6 months, 3) improve Activities of Daily Living mean scores by 7% over baseline for patient enrolled in VPN for at least 6 months and create a robust, multidisciplinary care team that manages everything for the patient from scheduling appointments, receiving labs/medications to addressing social issues and helping the patient to overcome barriers to care. We expect that ED and inpatient utilization will decrease and this cohort of high risk patients will have improved clinical outcomes and fewer downstream disease complications/issues.

Starting Point/Baseline

The baseline for this project at Baylor Medical Center at Irving does not exist. The program at Baylor University Medical Center has not been rigorously tracked. Approximately 90 patients have been seen over the past 2 years. On average, patients remain in the program for 298 days. Currently, the patient panel for the program includes Medicare patients who, under this project will be transitioned to a different service. Although this project is an extension of the current

[250] RHP 9 Community Health Needs Assessment

[251] RHP 9 Community Health Needs Assessment.

[252] Gawande, A. "The hot spotters." *The New Yorker*, January 24, 2011

program Baylor Medical Center at Irving has in place, it has many new components (expanded care team, more services, greater frequency of visits, focus on Medicaid and Uninsured, etc).

Rationale

We selected this project because in the populations we serve, many times patients are unable or unwilling to come to the Baylor Clinic to receive the care they need. The Medicaid and uninsured populations have multiple social, economic and other barriers on top of clinical issues that prevent them from appropriately managing their health. This project uses a face to face mechanism whereby patients are monitored regularly and have all of their needs met in a venue that is convenient and comfortable for them. In a recent article in Health Affairs, entitled Six Features of Medicare coordinated care demonstration programs that cut hospital admissions of high risk patients, Brown found supplementing telephone calls to patients with frequent in-person meetings; occasionally meeting in person with providers; acting as a communications hub for providers; delivering evidence-based education to patients; providing strong medication management; and providing timely and comprehensive transitional care after hospitalizations were characteristics of successful care coordination programs.[253] Our project, the Vulnerable Patient Network incorporates these components into the program and furthers them by adding additional services such examinations and clinical decision making to changing urinary catheters, labs, vaccinations. The team we propose to put in place would be able to address all of these needs in a coordinated and fluid fashion.

Project Components

We plan engage in continuous quality improvement activities such as: identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Reasons for selecting outcome measures

The milestones and metrics we chose for this project are focused on identifying and intervening on high risk patients who are high utilizers of healthcare services and are unable or unwilling to receive care in an ambulatory care setting. There is one point of clarification needed around the target population for this project. We define the target population as the following:

- Numerator: The number of patients enrolled in the program
- Denominator: The number of patients referred from the hospital as identified by Care Coordinators/Navigators as possible candidates based on identified risk factors including but not limited to: homebound, disabled, multiple chronic diseases, polypharmacy or any other medical or social conditions limiting patients' ability to access care in ambulatory care setting

[253] Brown, RS. Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high risk patients. *Health Aff*. 2012 June; 21(6): 1156-1165.

The reason we selected outcome measures related to Quality of Life and Activities of Daily living was in order to emphasize the importance for the Care Team to identify and assess non-clinical barriers that may be impeding the patient from receiving the optimal level of care necessary to maintain and sustain their health status.

Unique community need identification number the project addresses: CN.3- Healthcare Capacity and CN.12 Emergency Department Usage and Readmissions

How the project significantly enhances an existing delivery system reform initiative

This project does not receive any federal funds and is a new initiative. It is focused on addressing the complex needs of the highest risk patients by bringing care into their homes.

Related Category 3 Outcome Measures

The Category 3 Outcomes chosen for this project are based upon expected improvement for quality of life and activities of daily living. Many of the components included in Quality of Life and Activities of Daily living assessments help the care team to identify barriers to care and increase compliance. Both measures would also help to periodically and regularly assess QOL and ADL measures to keep an updated record of the patient's barriers to care.

Outcome Measure #1: IT-10.1 Quality of Life (**Standalone measure**).

Quality of Life assessments such as the SF-36 or AQoL measure components such as: illness, independent living, social relationships, physical senses and psychological wellbeing and will be important to measure in the high risk and vulnerable patients we intend to serve.[254] Understanding social and physical attributes of the patient will be essential in determining their feasibility of following protocols and regimens that will optimize their healthcare. We plan on conducting a QOL assessment every 6 months on patients who have been in the program for at least 6 months. Improvement will be measured from the time the patient is enrolled to time of survey administration.

Outcome Measure #2: IT-10.2 Activities of Daily Living (**Standalone measure**).

Measurement of the activities of daily living is critical because they have been found to be significant predictors of paid home care , use of hospital services, living arrangements, use of physician, insurance coverage and mortality.[255] While ADLs are typically used with the elderly population, the complexity and nature of the high risk uninsured/Medicaid patients warrants this assessment as well. Monitoring the progress or decline of factors such as bathing, feeding, continence, transferring, toileting and dressing are immediate predictors of any issues or barriers that patients may be experiencing.[256] We may need to consider using the Lawton IADL scale for this population as it involves more complex activities such as: shopping, laundry,

[254] Hawthorne, G. The assessment of quality of life instrument: a psychometric measure of health related quality of life. *Qual Life Res.*8(3):209-24 (1999)

[255] Measuring ADLs Across National Surveys: http://aspe.hhs.gov/daltcp/reports/meacmpes.htm

[256] Katz, Sidney. 1983. "Assessing Self-Maintenance: Activities of Daily Living, Mobility, and Instrumental Activities of Daily Living." *Journal of the American Geriatrics Association* 31:721-727.

responsibility for own medications, etc.[257] We plan on conducting the ADL assessment every 6 months and patients that have been in the program for 6 months. The improvement will be measured from the time that patients enroll in the program to survey conduction.

Relationship to other Projects

121776204.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
Patients that are in the Vulnerable Patient Network can come from the Baylor Clinic. Patients that are identified as high risk from the Baylor Clinic are candidates for the VPN program.

Category 4 Population-focused improvements

This project will help to support, reinforce and enable Category 4 population focused improvements through project design and appropriate intervention for targeted populations:

The thought here is that if patients receive the care they need they will have improved clinical outcomes and fewer ED or inpatient admissions.
RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.7, RD-1.8, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7, RD-4.1, RD-4.2

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

Care Coordination models require an initial connection but also require resources to triage patients to. Once a patient is identified to need a PCP/PCMH or another community resource, it becomes the Region's responsibility to ensure there are outlets for these patients to receive the care they need.

Performing Provider	Unique Project Number
Baylor Medical Center at Garland	121790303.2.4
Baylor University Medical Center	139485012.2.4
Children's Medical Center	138910807.2.4
Doctors Hospital at White Rock (Tenet)	094194002.2.2
Parkland Health & Hospital System	127295703.2.9
University of Texas Southwestern – Faculty	126686802.2.5
University of Texas Southwestern – Hospital	175287501.2.3

Plan for Learning Collaborative. We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

[257] Lawton, M. Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living. *The Gerontologist* 9:179-186.

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced our projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. That model computes separate values for impacts on the health care system, the individual and the community. ***Baylor Medical Center at Irving*** defined the population that will be directly impacted by the project as the underserved/ uninsured patients are considered high risk both clinically and socioeconomically. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 4. We believe when a person is connected to comprehensive care, available to them in their homes, compliance and outcomes both improve. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a *3.* We believe when a person is positively impacted, their ED utilization decreases, community resource burdens are relieved and a greater number of people receive care. In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121776204.2.4	***2.12.2***	***CQI***	***IMPLEMENT PILOT INTERVENTION IN CARE TRANSITIONS-*** *VULNERABLE PATIENT NETWORK (VPN)*
Baylor Medical Center at Irving			*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.16* *121776204.3.17*	*3.IT-10.1* *3.IT-10.2*	*Quality of Life (**Standalone measure**)* *Activities of Daily Living (**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-5]: Using a validated risk assessment tool, create a patient identification system Metric 1 [P-5.1]: Patient stratification system Baseline/Goal: Develop and validate risk assessment tool Data Source: Documentation tool options and assessments Milestone 1 Estimated Incentive Payment *(maximum amount):* $125,250 **Milestone 2** [P-7]: Develop a staffing and implementation plan to complete goals/objectives of the care transitions program Metric 1 [P-7.1]: Documentation of staffing plan Baseline/Goal: Create staffing plan for care team Data Source: Staffing and implementation plan Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 125,250	**Milestone 3** [P-5]: Using a validated risk assessment tool, create a patient identification system Metric 1 [P-5.1]: Patient stratification system Goal: Implement risk assessment tool Data Source: Submission of risk assessment tool and patient stratification report and description of provider utilization report of findings Milestone 3 Estimated Incentive Payment: $91,094 **Milestone 4** [P-9]: Implement a case management related registry Metric 1 [P-9.1]: Documentation of registry implementation Goal: Implement and validate registry Data Source: Registry reports demonstrating case management functionality Milestone 4 Estimated Incentive Payment: $91,094	**Milestone 6** [I-15]: Improve care transitions using innovative project option Metric 1 [I-15.1]: Increase percentage of target population reached Goal: Increase percentage of target population reached by 25% (or at least 30 patients enrolled over DY2) Numerator: Number of patients enrolled in intervention Denominator: Number of patients referred from the hospital as potential candidates based on risk factors Data Source: Documentation of target population reached Metric 2 [I-15.2]: Evaluate the intervention(s) Goal: Report number of patients transitioned by type of transition Data Source: data file of all transitioned patient in one year Metric 3 [I-15.3]: Percentage of patients, regardless of age discharged from an inpatient facility to home or any other site of care for whom a transition	**Milestone 7** [I-15]: Improve care transitions using innovative project option Metric 1 [I-15.1]: Increase percentage of target population reached Goal: Increase percentage of target population reached by 35% (or at least 50 patients enrolled over DY2) Numerator: Number of patients enrolled in intervention Denominator: Number of patients referred from the hospital as potential candidates based on risk factors Data Source: Documentation of target population reached Metric 2 [I-15.2]: Evaluate the intervention(s) Goal: Report number of patients transitioned by type of transition Data Source: data file of all transitioned patient in one year Metric 3 [I-15.3]: Percentage of patients, regardless of age discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary care physician or other health care professional designated for follow-up within 24 hours of discharge

121776204.2.4	***2.12.2***	***CQI***	***IMPLEMENT PILOT INTERVENTION IN CARE TRANSITIONS-*** *VULNERABLE PATIENT NETWORK (VPN)*
Baylor Medical Center at Irving			*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.16* *121776204.3.17*	*3.IT-10.1* *3.IT-10.2*	*Quality of Life (**Standalone measure**)* *Activities of Daily Living (**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 5 [I-15]: Improve care transitions using innovative project Metric 1 [I-15.1]: Increase percentage of target population reached Goal: Increase percentage of target population reached by 15% (or at least 15 patients enrolled over DY2) Numerator: Number of patients enrolled Denominator: # patients referred from hospital as potential candidates based on risk factors Data Source: Documentation of target population reached Metric 2 [I-15.2]: Evaluate the intervention(s) Goal: Report number of patients transitioned by type of transition Data Source: data file of all transitioned patient in one year Metric 3 [I-15.3]: Percentage of patients, regardless of age discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary care physician or	record was transmitted to the facility or primary care physician or other health care professional designated for follow-up within 24 hours of discharge Goal: Report percentage of patients for whom a transition record was transmitted to a facility or primary care of other health care professional designated for follow-up within 24 hours of discharge Data Source: data file of all transitioned patient in one year Metric 4 [I-15.4]: Percentage of patients regardless of age, discharged from an emergency department to ambulatory care or home health, or their caregiver, who received a transition record at the time of ED discharge Goal: Report number of patients who received a transition record at the time of ED discharge including: major procedures and tests performed during ED visit, principal diagnosis (or chief complaint), patient instructions, plan for follow up care (or statement that none was required), list of new medications	Goal: Report percentage of patients for whom a transition record was transmitted to a facility or primary care of other health care professional designated for follow-up within 24 hours of discharge Data Source: data file of all transitioned patient in one year Metric 4 [I-15.4]: Percentage of patients regardless of age, discharged from an emergency department to ambulatory care or home health, or their caregiver, who received a transition record at the time of ED discharge Goal: Report number of patients who received a transition record at the time of ED discharge including: major procedures and tests performed during ED visit, principal diagnosis (or chief complaint), patient instructions, plan for follow up care (or statement that none was required), list of new medications and changes to continued medications that patient should take after ED discharge Data Source: EHR Milestone 7 Estimated Incentive Payment: $226,411

121776204.2.4	***2.12.2***	***CQI***	***IMPLEMENT PILOT INTERVENTION IN CARE TRANSITIONS-*** *VULNERABLE PATIENT NETWORK (VPN)*	
Baylor Medical Center at Irving				*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.16* *121776204.3.17*	*3.IT-10.1* *3.IT-10.2*	*Quality of Life (**Standalone measure**)* *Activities of Daily Living (**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)**
	other health care professional designated for follow-up within 24 hours of discharge Goal: Report percentage of patients for whom a transition record was transmitted to a facility or primary care of other health care professional designated for follow-up within 24 hours of discharge Data Source: data file of all transitioned patient in one year <u>Metric 4</u> [I-15.4]: Percentage of patients regardless of age, discharged from an emergency department to ambulatory care or home health, or their caregiver, who received a transition record at the time of ED discharge Goal: Report number of patients who received a transition record at the time of ED discharge including: major procedures and tests performed during ED visit, principal diagnosis (or chief complaint), patient instructions, plan for follow up or statement that none was required), list of new meds, changes to continued medications patient should take after ED discharge		and changes to continued medications that patient should take after ED discharge Data Source: EHR Milestone 6 Estimated Incentive Payment: $274,076	

121776204.2.4	***2.12.2***	***CQI***	***IMPLEMENT PILOT INTERVENTION IN CARE TRANSITIONS-*** *VULNERABLE PATIENT NETWORK (VPN)*
Baylor Medical Center at Irving			*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.16* *121776204.3.17*	*3.IT-10.1* *3.IT-10.2*	*Quality of Life (**Standalone measure**)* *Activities of Daily Living (**Standalone measure**)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Data Source: EHR Milestone 5 Estimated Incentive Payment: $91,094		
Year 2 Estimated Milestone Bundle Amount: $ 250,500	Year 3 Estimated Milestone Bundle Amount: $273,282	Year 4 Estimated Milestone Bundle Amount: $274,076	Year 5 Estimated Milestone Bundle Amount: $226,411
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5): $1,024,269*			

Project Option 2.11.3 – Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

RHP Project Identifier: 121776204.2.5 – Pass 2
Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Provider: Located in the heart of the Dallas-Fort Worth Metroplex, Baylor Irving serves Irving, Las Colinas and the surrounding communities. The not-for-profit 296-bed hospital offers advanced treatment capabilities in cardiology, orthopedics, oncology, digestive disorders, diagnostic imaging, physical medicine and emergency care. Baylor Irving's service area represents a population of 546,000.

Intervention(s): This project will provide medication management and reconciliation services to uninsured and Medicaid patients at the Baylor Clinic on the Baylor Medical Center at Irving campus. Patients who are 150% or below the FPL and/or have chronic illnesses can qualify for prescription assistance. A clinical pharmacist will be responsible for oversight of prescriptions, educate patients about how and why to take their medications and review utilization, appropriateness and efficacy of medications that patients have been prescribed. This project is a new initiative and contributes to creating a complete PCMH for underserved patients.

Need for the project: Non-compliance to medications can lead to complications and clinical exacerbations that are often avoidable with proper management and education. Medications are an important part of a patient's care regimen but can become an impediment to care when issues such as access or cost become prevalent. This project will help to overcome these issues.

Target population: Baylor Clinic patients who have multiple medications, chronic diseases and/or have demonstrated need for prescription assistance. At least 90% of patients served will be Uninsured/Medicaid.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide medication management to 185 patients.

Category 3 outcomes: Category 3 outcomes for this project do not have any baseline data and improvements are based on ranges of current performance.

- **IT-1.2** Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs (Non- standalone measure). Our goal is to increase the appropriate monitoring tests from at least 2% in DY3 to at least 6% in DY5.
- **IT-1.4** Annual monitoring for patients on persistent medications– diuretic (Non-standalone measure). Our goal is to increase the appropriate monitoring tests from at least 2% in DY3 to at least 6% in DY5.

- **IT-1.5** Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)**.** Our goal is to increase the appropriate monitoring tests from at least 2% in DY3 to at least 6% in DY5.
- **IT-1.19** Antidepressant Medication Management - (Standalone measure). Our goal is to increase effective acute phase treatment by 5% in DY3 to 15% in DY5 and to increase continuous phase treatment by 3% in DY3 to 7% in DY5.

Project Description

This project option combines project options 2.11.1- Implement interventions that put in place teams, technology and processes to avoid medication errors and 2.11.2- Evidence based interventions that put in place the teams, technology and processes to avoid medication errors. The project option we chose combines the components of both of these project options but focuses on medication management and compliance in the ambulatory setting within the patient's Baylor Clinic PCMH. . Based on current estimates by our providers, we anticipate that more than 50% of patients in the Baylor Clinic have five or more medications. Ensuring that these medications are 1) appropriate, 2) taken correctly, 3) managed and 4) accessible will be important to improve clinical outcomes. By combining two of the project options 2.11.1 and 2.11.2 to create an "other" option encompasses both a process for avoiding medication errors and evidence based interventions to avoid medication errors. We intend to utilize a clinical pharmacist who will review patient mediations for those patients who have multiple prescriptions on a regular basis to ensure that medications are appropriate and to ensure the patient understands how and why they are taking the medications. Additionally, we plan to help patients obtain the medications they need through implementing a prescription assistance program to help patients who are eligible, qualify for mediations and provide medications to those patients who cannot afford prescriptions. We will attempt to provide medications at little to no cost for patients who are 150% below the federal poverty level, have one or more chronic diseases and remain compliant with their appointments and care regimens. Through this benefit and clinical pharmacist oversight and management, we expect adherence and compliance to medications will increase. The additional advantage to embedding this team within the PCMH is that patients will receive comprehensive care management to address all of their needs in one care venue.

Goals and Relationship to Regional Goals

The goals for this project are: 1) to provide prescriptions at little to no cost for patients that qualify or help patients enroll in programs to receive their medications, 2) provide clinical pharmacist oversight to ensure that medications are appropriate and adhered to, 3) patients understand their medications and reasons for taking them 4) improve clinical outcomes related to adhering to a medication regimen. The regional goals around managing chronic disease, ED utilization and behavioral health are all addressed through this project. Managing medications has ancillary effects on outcomes of multiple regional goals. If patients have access to and adhere to their prescriptions, chronic diseases and behavioral health issues would be under better control and there would be fewer exacerbations and visits to the ED. This program is also

a mechanism to improve cost savings for the region through monitoring utilization, finding generic prescriptions where appropriate and avoiding costly complications and expensive ED/inpatient utilization.

Challenges

Challenges with the underserved population and medication management pose one of the most difficult hurdles to overcome in their care. First, the uninsured and Medicaid populations are highly transient and may not maintain the same PCMH for an extended period of time. This causes gaps in their medication regimen and can often lead to clinical exacerbations. Another challenge is access to medications and affordability. Patients who do not live near a pharmacy to fill their prescriptions or cannot afford to fill them will forgo this part of their care or ration the medications they have, leading to complications and escalations in their conditions. One trend we have seen in RHP 9 is indigent patients will go from ED to ED across the region to receive pain medications and because there is little coordination between hospital systems, there is no consistent record of the medications these patients receive. Lastly, patients that are polypharmacy often do not understand how to take their mediations appropriately or understand why they need the prescription at all. This lack of understanding also leads to non-compliance. With this project, we plan to address these challenges by providing medications at little to no cost for those patients that qualify, help patients that are eligible get on prescription assistance programs, provide prescriptions in the Baylor Clinic or nearby on the Baylor campus and offer clinical pharmacist oversight to monitor the patients' prescriptions and encourage compliance to a medication regimen.

5-year Expected Outcome for Provider and Patients

The 5-year expected outcomes for this project include: 1) a minimum of 185 patients with medication management in a PCMH setting, 2) increased frequency of medication reconciliation and management, 3) greater literacy around medication regimens and purposes, 4) efficient and effective utilization of medications for patients and 5) make the clinical pharmacist part of the PCMH care team. We through proactive management of mediations for the uninsured and Medicaid populations that clinical outcomes will improve, there will be fewer exacerbations of patient diseases.

Starting Point/Baseline

Baylor clinics have not historically provided any type of formal medication management or prescription assistance type program to patients. This is a new program that will be offered. We anticipate that on average about 5% of Baylor Clinic patients will need medication management services. Based on historical data, almost 50% of patients have five or more prescriptions. We anticipate that on average about 5-10% of high risk Baylor Clinic patients will need focused and frequent medication management services. We will have to establish the baseline in DY2 for the particular medications mentioned in the Category 3 outcomes and to determine the scope of high risk and polypharmacy patients.

Rationale

We selected this project for multiple reasons: 1) to offer a complete suite of services to patients in a Baylor Clinic PCMH ranging from chronic disease and behavioral management, basic primary care, specialty care and medications, 2) provide regular medication management and reconciliation to ensure appropriate utilization and adherence to prescriptions, 3) improve clinical outcomes by enforcing a medication regimen with patients and 4) improve adherence to medications by offering assistance in obtaining them. Successful programs that focus on coordinating care for patients include a medication management component.[258] Our overall goal is to create a PCMH for uninsured and Medicaid patients that is comprehensive and has co-located services to allow for greater convenience and compliance for patients. The total economic impact of medication non-adherence — which contributes to costly health complications, worsening of disease progression, and preventable utilization — has been estimated to be as much as $290 billion.[259] For patients with diabetes, those with low levels of adherence have almost twice the total annual healthcare costs of those with high levels of adherence ($16,498 versus $8,886).[260] The New England Healthcare Institute cited four components to improving medication management: 1) creating health care teams, 2) patient engagement and education, 3) payment reform and 4) leveraging health information technology.[261] This project addresses all of these components by 1) integrating the clinical pharmacist into the PCMH team, 2) educating the patient on why and how to take their medications, 3) offering prescription assistance and little to no cost medications for those who qualify and 4) using the Baylor Clinic electronic health record to monitor prescription regimens, fulfillments and utilization. There have been studies published stating that giving patients medications for free does not promote utilization and adherence.[262] In a study published in the New England Journal of Medicine, insured patients who were discharged from the hospital and had their prescriptions fully covered still only had adherence rates of 40-50%.[263] We will control for this in two ways: 1) we will not offer prescriptions for free unless the patient is 150% or below the FPL and/or has at least 1 chronic disease and 2) we will require that a patient is seen regularly in the Baylor Clinic to continue to receive their medications.

Project Components

We have chosen applicable components from project options 2.11.1 and 2.11.2 to create our project around medication management

[258] Brown, RS. Six features of Medicare coordinated demonstration programs that cut hospital readmissions of high risk patients. *Health Aff*. 2012 June; 31(6):1156-1165.

[259] McKethan, A and Benner, J. Seizing the opportunity to improve medication adherence. *Health Aff.* 2012 August.

[260] New England Healthcare Institute. Thinking outside the pillbox: a systemwide approach to improving medication adherence for chronic disease. 2009 August.

[261] New England Healthcare Institute. Thinking outside the pillbox: a systemwide approach to improving medication adherence for chronic disease. 2009 August.

[262] McKethan, A and Benner, J. Seizing the opportunity to improve medication adherence. *Health Aff.* 2012 August.

[263] Choudhry, NK, Avorn, J, et. al. Full coverage for preventive medications after myocardial infarction. N Engl J Med 2011; 365:2088-2097

a. Develop criteria and identify targeted patient populations that are at high risk for developing complications, co-morbidities and/or utilizing emergency care services: *We will use our electronic health record to identify polypharmacy patients, patients who are on chronic disease medications and/or are high utilizers of the ED*

b. Develop tools to provide education and support to those patients at highest risk of an adverse drug event or medication error. *The clinical pharmacist we use for this program will help to educate the patient on these topics. We will ensure that materials are multilingual as well.*

c. Conduct root cause analysis of potential medication errors or adverse drug events and develop/implement processes to address those causes: *As one of our metrics, we will be designing the workflow for the clinical pharmacist and we will add this component into plan*

d. Implement pharmacist led chronic disease medication management services in collaboration with primary care and other healthcare providers: *The clinical pharmacist will be co-located in the Baylor Clinic and will interface with the PCMH team on a regular basis*

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. *This project will be part of an overall Baylor initiative that will be analyzing and evaluating the progress and challenges/barriers for all DSRIP projects. We will focus on identifying key challenges associated with the expansion and opportunities to scale the project where appropriate.*

Reasons for selecting outcome measures

The milestones and metrics we chose for this project are focused on increasing the number of patients who receive medication management services and by having outcomes that specifically focus on medications, this will encourage the care team to manage and monitor medications more frequently and with higher scrutiny. Although medication management is part of the patient's overall care in a Baylor Clinic, these milestones, metrics and outcomes will put a greater emphasis on ensuring that mediations are appropriate, regularly reconciled, adhered to and are utilized in order to improve clinical outcomes for patients. The outcome measure medications that we chose: ACE/ARB inhibitors, diuretics, anticonvulsants and antidepressants are drugs that are regularly used by our Baylor Clinic patients. Since many of

our patients have hypertension and CHF, adherence improvement to these drugs will help to facilitate better outcomes.

Unique community need identification number the project addresses:
CN.11 Patient Safety and Quality and CN.4 Primary Care and Pediatrics

How the project significantly enhances an existing delivery system reform initiative
This project does not receive any federal funds and is a new initiative. It is focused on providing prescriptions for patients in need and ensuring that utilization of these prescriptions is appropriate and (cost and clinically) effective.

Related Category 3 Outcome Measures
The Category 3 outcomes for this project focus on medication management and monitoring for specific drugs that many of our Baylor Clinic use. These medications are also associated with complex chronic diseases and behavioral health issues. These drugs are an important part of a patient's care regimen to keep their conditions well controlled.

Outcome Measure #1: IT-1.2 Annual monitoring for patients on persistent medications angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non-standalone measure).
Approximately 33% of Baylor Clinic patients are on an ACE/ARB medication regimen. Enforcing annual monitoring will improve quality and reconcile the patient's medication to ensure it is still appropriate. In a recent study in the New England Journal of Medicine, compliance to antihypertensives was 41%, beta blockers was 49% and statins were 55% after a patient suffered from an AMI.[264] We believe through consistent, proactive management and encouraging patient accountability for taking medications, these rates should increase.

Outcome Measure #2: IT-1.4 Annual monitoring for patients on persistent medications–diuretic (Non- standalone measure)
Approximately 33% of Baylor Clinic patients on a diuretic medication regimen. Enforcing annual monitoring will improve quality and reconcile the patient's medication to ensure it is still appropriate. A study that observed the correlation between a diuretic regimen and cardiovascular related hospitalizations found that patients who take the appropriate dose of diuretics at the appropriate time had a decrease risk of cardiovascular and heart failure related hospitalizations. A large component of the successful adherence was attributed to patient education and engagement in the medication regimen.[265]

[264] Choudhry, NK, Avorn, J, et. al. Full coverage for preventive medications after myocardial infarction. N Engl J Med 2011; 365:2088-2097

[265] Chui, M. A., Deer, M., Bennett, S. J., Tu, W., Oury, S., Brater, D. C. and Murray, M. D. (2003), Association Between Adherence to Diuretic Therapy and Health Care Utilization in Patients with Heart Failure. Pharmacotherapy, 23: 326–332. doi: 10.1592/phco.23.3.326.32112

Outcome Measure #3: IT-1.5 Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)
Only about 5% of Baylor Clinic patients are on an anticonvulsant medication regimen. This may be because there are no formal behavioral health programs in the Baylor Clinic, it is possible that identification of BH issues is low and utilization of anticonvulsants would increase with an increased emphasis on identifying BH issues. A study in Psychiatric Services found that 50% of patients that were given anticonvulsant prescriptions to treat bipolar disorder were non-adherent.[266] This issue can be resolved by explaining the risks v. benefits for taking an anticonvulsant.

Outcome Measure #4: IT-1.19 Antidepressant Medication Management - (Standalone measure)
Approximately 20% of Baylor Clinic patients on an antidepressant medication regimen. According to the Community Health Needs Assessment, behavioral health is a major issue in the region. The top 10 utilizers in the region had behavioral health related issues.[267] While antidepressants are not the solution to this problem, managing depression can have other positive ancillary effects on clinical adherence and avoidance of BH exacerbations. This outcome enforces both short and long term adherence to this drug in order to avoid adverse events for patients. An article in the Journal of Clinical Psychiatry, evidence was found "…to support collaborative care interventions in a primary care setting demonstrated significant improvements in antidepressant drug adherence during the acute and continuous phase of treatment and were associated with clinical benefit, especially in patients suffering from major depression and were prescribed adequate dosages of antidepressant medication.[268]" Our project supports this methodology.

Relationship to other Projects

121776204.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
This medication management and prescription assistance program will be available to patients who are Baylor Clinic patients. The program will be incorporated into the overall care team and management of the patient.

Category 4 Population-focused improvements

This project will help to support, reinforce and enable Category 4 population focused improvements through project design and appropriate intervention for targeted populations: The thought here is that if patients take the appropriate medications in the right dose and correct regimen, the following improvements can be expected:
RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.8, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7, RD-3, RD-4.1, RD-4.2

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

[266] Sajattovic, M, et. al. Treatment adherence with lithium and anticonvulsant medications among patients with bipolar disorder. *Psychiatric Services*. 58(6):855-63. 2007.
[267] RHP 9 Community Health Needs Assessment
[268] Vergouwen, AC, et. al. Improving adherence to antidepressants: a systematic review of interventions. *J Clin Psychiatry.* 64(12):1415-20. 2003.

TBD

Plan for Learning Collaborative

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same process and technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced our projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor Medical Center at Irving defined the population that will be directly impacted by the project as the underserved/uninsured patients that need prescription assistance and medication management services that are patients at a Baylor Clinic PCMH on the ***Baylor Medical Center at Irving*** campus. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3. We believe this to be the correct number because, when a person is on the correct prescription and on an appropriate medication regimen, they are better able to manage their illnesses and have better clinical outcomes. To determine the value to the community of each, we concluded that, on a scale of 1 – 5, the value of this project is a *3.* We believe this to be the correct number because, when a person is positively impacted, unnecessary drug utilization decreases, patients are able to become well and resume being active and productive members in society.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the

weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

121776204.2.5	***2.11.3***	***2.11.3 (A-F)***	***OTHER PROJECT OPTION- EVIDENCE BASED INTERVENTIONS THAT PUT IN PLACE TEAMS, TECHNOLOGY AND PROCESSES TO ENSURE MEDICATION COMPLIANCE AND MANAGEMENT- MEDICATION MANAGEMENT AND PRESCRIPTION ASSISTANCE PROGRAM***
Baylor Medical Center at Irving			*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.18* *121776204.3.19* *121776204.3.20* *121776204.3.21*	*3.IT-1.2* *3.IT-1.4* *3.IT-1.5* *3.IT-1.19*	*Annual monitoring for patients on persistent medications angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non- standalone measure)* *Annual monitoring for patients on persistent medications– diuretic (Non- standalone measure)* *Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)* *Antidepressant Medication Management - (Standalone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Implement/expand a medication management program/system Metric 1 [P-1.1]: Program elements Baseline/Goal: Determine program elements: people, processes and technologies Data Source: Documentation of program and written medication management plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $111,071 **Milestone 2** [P-2]: Develop criteria and identify patient populations Metric 1 [P-2.1]: Establish evidence based criteria for medication management planning in target population based on assessment of population needs Baseline/Goal: Conduct needs	**Milestone 3** [P-1]: Implement/expand a medication management program/system Metric 1 [P-1.1]: Program elements Baseline/Goal: Create workflow and medication management plans for patients Data Source: Documentation of written medication management plan and provider workflow Milestone 3 Estimated Incentive Payment *(maximum amount):* $80,781 **Milestone 4** [P-4]: Implement an evidence based program based on best practices for medication reconciliation to improve medication management and continuity between acute care and ambulatory setting Metric 1 [P-4.1]: Written plan to provide medication reconciliation as	**Milestone 6** [I-9]: Manage medications for targeted patients Metric 1 [I-9.1]: Increase number of patients (meeting criteria for chronic condition) contacted or receiving medication management Goal: Provide medication management services to at least 125 patients over DY2 Data Source: E.H.R. Milestone 6 Estimated Incentive Payment *(maximum amount):* $243,049	**Milestone 7** [I-9]: Manage medications for targeted patients Metric 1 [I-9.1]: Increase number of patients (meeting criteria for chronic condition) contacted or receiving medication management Goal: Provide medication management services to at least 185 patients over DY2 Data Source: E.H.R. Milestone 7 Estimated Incentive Payment *(maximum amount):* $200,779

121776204.2.5	***2.11.3***	***2.11.3 (A-F)***	***OTHER PROJECT OPTION- EVIDENCE BASED INTERVENTIONS THAT PUT IN PLACE TEAMS, TECHNOLOGY AND PROCESSES TO ENSURE MEDICATION COMPLIANCE AND MANAGEMENT- MEDICATION MANAGEMENT AND PRESCRIPTION ASSISTANCE PROGRAM***
Baylor Medical Center at Irving			*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.18* *121776204.3.19* *121776204.3.20* *121776204.3.21*	*3.IT-1.2* *3.IT-1.4* *3.IT-1.5* *3.IT-1.19*	*Annual monitoring for patients on persistent medications angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non- standalone measure)* *Annual monitoring for patients on persistent medications– diuretic (Non- standalone measure)* *Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)* *Antidepressant Medication Management - (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)**
assessment to determine target population and medication needs Data Source: Written criterion for target population and program participation. Milestone 2 Estimated Incentive Payment *(maximum amount):* $111,070	part of transition from acute care to ambulatory care Baseline/Goal: Create plan for medication reconciliation Data Source: Documentation of program policies and procedures that ensure medication reconciliation upon admission and discharge at each care setting Milestone 4 Estimated Incentive Payment *(maximum amount):* $80,781 **Milestone 5** [I-9]: Manage medications for targeted patients <u>Metric 1</u> [I-9.1]: Increase number of patients (meeting criteria for chronic condition) contacted or receiving medication management Goal: Provide medication management services to at least 100 patients over DY2 Data Source: E.H.R.		

121776204.2.5	***2.11.3***	***2.11.3 (A-F)***	***OTHER PROJECT OPTION- EVIDENCE BASED INTERVENTIONS THAT PUT IN PLACE TEAMS, TECHNOLOGY AND PROCESSES TO ENSURE MEDICATION COMPLIANCE AND MANAGEMENT- MEDICATION MANAGEMENT AND PRESCRIPTION ASSISTANCE PROGRAM***
Baylor Medical Center at Irving			*121776204*
Related Category 3 Outcome Measure(s):	*121776204.3.18* *121776204.3.19* *121776204.3.20* *121776204.3.21*	*3.IT-1.2* *3.IT-1.4* *3.IT-1.5* *3.IT-1.19*	*Annual monitoring for patients on persistent medications angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non- standalone measure)* *Annual monitoring for patients on persistent medications– diuretic (Non- standalone measure)* *Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)* *Antidepressant Medication Management - (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 5 Estimated Incentive Payment *(maximum amount):* $80,782		
Year 2 Estimated Milestone Bundle Amount: $ 222,141	Year 3 Estimated Milestone Bundle Amount: $242,344	Year 4 Estimated Milestone Bundle Amount: $243,049	Year 5 Estimated Milestone Bundle Amount: $200,779
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $908,313			

Project Option 2.2.2 – Expand Chronic Care Management Model - Create Chronic Disease management and Prevention Program

RHP Project Identifier: 139485012.2.1
Performing Provider Name/TPI: Baylor University Medical Center/139485012

Provider: Baylor University Medical Center at Dallas (Baylor Dallas) is a nationally recognized hospital that cares for more than 300,000 people each year. It is a major patient care, teaching and research center for the Southwest. Baylor Dallas has 1,065 licensed beds and serves as the flagship hospital of Baylor Health Care System. Located in Dallas, Baylor Dallas' service area represents a population of 4.2 million.

Intervention(s): The project purpose is to provide focused education and point of care testing for underserved patients who have diabetes, CVD and/or Respiratory disease that are in need of education, clinical management and training within a primary care setting. We will co-locate primary care and chronic disease management services to improve clinical outcomes. This project is new because it will provide CHF and Asthma education and point of care testing, all which have not been done before. We have had some Diabetes education in our Clinics but not a formal and focused program for the Medicaid/Uninsured population.

Need for the project: One of the major identified by the Community Health Needs Assessment for Region 9 included Chronic Disease. Components of patient education and helping patients to understand their illness, how to better manage it, how to coordinate their lifestyle choices and offering point of care testing in order to achieve optimal health outcomes are essential in population management of chronic disease

Target population: Approximately 275,000 individuals in Dallas County have Diabetes. 19.6% of Dallas County has Asthma, which equates to 473,000 people. CHF accounts for about 200 deaths per 100,000 individuals in Dallas County. The underserved segment of this population is who we will target.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide chronic disease education and point of care testing for 2073 patients in the Dallas area. We expect that this program's participants will be 85-90% Medicaid/Uninsured patients.

Category 3 outcomes: Category 3 outcomes for this project were chosen because: 1) the ambulatory setting of the project and 2) historical trends of metrics that had material impact on patients in a 2-3 year time period.

- IT-1.10: Diabetes Care: HbA1c Poor Control. Our goal is to decrease the number of patients with uncontrolled HbA1cs (> 9.0%) from 17.4% currently to 14.9% (or 2.5% improvement over baseline) in DY5.

- IT-1.11: Diabetes Care: BP Control (< 140/80 mmHg). Our goal is to increase the number of diabetic patients in good BP control (< 140/80 mmHg) from 49.4% to 56.6% (or 7.2% improvement over baseline) in DY5.

- IT-1.13: Diabetes Care: Foot Exam. Our goal is to increase the number of diabetic patients who receive foot exams from 86.8% currently to 90.4% (or 3.6% improvement over baseline) in DY5.

Project Description

The Baylor Clinic on the Baylor University Medical Center campus, would house a carved out chronic disease management program to provide focused and dedicated education and care for (Uninsured and Medicaid) patients with Diabetes, Cardiovascular Diseases (CVD) (i.e.: Congestive Heart Failure) and Respiratory Diseases (Asthma/Chronic Obstructive Pulmonary Disease) within a primary care setting. We expect that this program's participants will be 85-90% Medicaid/Uninsured patients. Specific staff, comprised of CHWs and Nurse Care Managers, would address the complex clinical and prevention needs of these patients and spend time specifically on management of these diseases. The focus of this time and education with patients would not only entail clinical counseling, but also include prevention components to focus on lifestyle issues and self-management. The other key advantage that patients will receive as part of this program is point of care testing for Diabetes (HbA1c testing and glucose testing using test strips) and Asthma (Peak Flow Meter Assessments). We believe this will overcome the barrier of patients' non-compliance with completing lab orders and any financial or transportation issues that would arise in obtaining these important lab results.

We plan to leverage the expertise and experience of both the Diabetes Health and Wellness Institute (Baylor entity in South Dallas) and Baylor Clinics to provide staff education, develop competencies, and create protocols that will result in a complete and robust program tailored for multiple community settings. The Diabetes Health and Wellness Institute would house this staff and appropriately triage and manage providers to see patient at Baylor Clinics based on volume and demand parameters. Baylor Clinics have had previous success in managing patients with chronic disease through the creation and development of a community health worker model (CHW). These successes and competencies will be leveraged to create programs around CVD and Respiratory illnesses.

Goals and Relationship to Regional Goals

The project goals for this program include: 1) increasing health literacy around chronic illnesses for patients in the community, 2) educate and teach self-management techniques for patients to manage their chronic diseases, 3) augmenting RN care managers with CHWs to serve a greater number of patient through a carved out, focused care model, 4) increasing the number of patients who are screened and monitored for their chronic diseases using point of care testing and 5) increase education for patients with CHF and Asthma/COPD (2 disease states previously not offered). The purpose for performing a project in this area is to help identify

patients with chronic diseases and provide them with treatment and education in a proactive fashion so that downstream complications can be avoided and ED/inpatient utilization can decrease.

One of the major identified by the Community Health Needs Assessment for Region 9 included Chronic Disease[269]. Components of patient education and helping patients to understand their illness, how to better manage it and how to coordinate their lifestyle choices to achieve optimal health outcomes are essential in population management of chronic disease. This project coincides with this need and focuses on education, lifestyle management, proactive counseling and decision making and clinical improvement. This leads to lower ED visits for acute issues related to chronic diseases and helps patients utilize costly services in the Region.

Challenges

Underserved patients experience multiple barriers to effectively manage their chronic illnesses. These include lack of knowledge, lack of social support, poor diets, insufficient physical activity, and limited access to care due to financial and transportation issues. By co-locating the chronic care management program within the primary care clinic, patients can receive medical care and chronic disease support at the same time. Additionally, the PCP's medical management is informed by the chronic care management team's interactions with the patient, which, in our experience, elicits new information regarding lifestyle and barriers to health. The RN/CHW model will be structured so that patient education is delivered in a format and context that is understandable and enjoyable for the patient. Lastly, the education and counseling will include lifestyle and self-management techniques so that this population can find ways to care for themselves that is relevant to their daily lives.

5-year Expected Outcome for Provider and Patients

The expected 5-year outcomes are that: 1) at least 2073 patients will have served by the Chronic Care Management model at the Baylor Clinic, 2) we expect better clinical outcomes around HbA1c, foot exam completion and BP control, 3) more patients in the community will have had a point of care test completed for their diabetes or asthma which will provide real time results and opportunities for improvement for the patient and provide, 4) increase literacy in the community around chronic diseases and 5) decrease rates of avoidable/unnecessary complications (i.e. amputations) due to chronic diseases.

Starting Point/Baseline

Currently, the Baylor Clinic on the Baylor University Medical Center offers a limited program focused on diabetes education. Of the patients enrolled in the program, approximately 17% of clinic patients have an HbA1c > 9.0. This baseline is not directly comparable to the proposed project for chronic care management because we will be including CHF and Asthma/COPD patients as well as part of the initiative. We estimated a target population based on the Community Health Needs Assessment, 11.4% of all Dallas County residents have diabetes, this equates to almost 275,000 individuals in the county. Literature shows that diabetes is more

[269] RHP 9 Community Health Needs Assessment

prevalent in the underserved community[270]. 19.6% of Dallas County has Asthma, which equates to 473,000 people. CHF accounts for about 200 deaths per 100,000 individuals in Dallas County. These statistics do not take into consideration any intersection of CHF, Asthma and Diabetes which makes individuals more complex and high risk. [271] Our project will serve approximately 2073 new patients of this population.

Rationale

We selected this project option because of the prevalence of chronic disease in the underserved population. Through co-locating primary care, behavioral health and chronic disease management services, we can improve clinical outcomes. By increasing the availability of chronic care services and utilizing a team based approach, more patients can receive focused attention for their complex needs and learn to self-manage their illnesses in an effective way. We have demonstrated statistically significant reductions in mean HbA1c measures with a CHW model currently embedded in Baylor Clinics[272]. Thus expanding educational services to serve more diabetes patients, and beginning to serve CHF and Asthma/COPD patients is a logical next step in improving the care of the population. The Community Health Needs Assessment identified the top 5 most prevalent conditions as: stroke, diabetes, CHF, failing kidneys and AMI. This project addresses 2 of these directly and 2 indirectly, it aligns exactly with the needs of the Region and the challenges that have been identified.[273]

Project Components

We will engage in continuous quality improvement activities throughout the duration of the project such as: 1) identifying key challenges with the expansion of this project, 2) determine opportunities to scale all or part of the project- depending on available resources and financial constraints, 3) find ways to continuously integrate the chronic disease management program into the care team as much as possible.

Reasons for selecting outcome measures

The Chronic Care Management metrics and milestones we have chosen focus on finding the appropriate model that would be effective in Dallas County that also addresses multiple chronic illnesses. Based on the complexities of the underserved population, we structured our metrics to focus on increasing access, awareness and education for individuals in the region and in the latter years including metrics around increased compliance to recommended clinical protocols. We believe it will take time for patients to understand and epitomize good self-management behaviors and it will also take times to see marked clinical outcome improvements. We do anticipate some clinical improvement for those patients that have been engaged in the chronic care management program for an extended period of time. We have not historically completed programs for CHF and Asthma/COPD and will use this opportunity to create a continuous

[270] RHP 9 Community Health Needs Assessment

[271] Healthy People North Texas: http://www.healthyntexas.org

[272] Walton, J, Snead, C. et.al. Reducing diabetes disparities through implementation of a community health worker led diabetes self-management education program. Journal of Family and Community Health. 2012: 35(2): 161-71.

[273] RHP 9 Community Health Needs Assessment

improvement environment where these programs can be refined and modified as we gather more experience.

Unique community need identification number the project addresses:
CN.8: Chronic Disease and need for chronic disease management

How the project significantly enhances an existing delivery system reform initiative
We currently do not receive any federal funding for chronic disease education and providing services for CHF and Asthma/COPD are new to the Baylor Clinic. This project coincides with the need to focus on chronic illnesses, as they are the main drivers of health care costs in the US. Diabetes alone costs the US almost $174 billion dollars a year. [274]

Related Category 3 Outcome Measures
Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

Outcome Measure #1: IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (**Standalone measure**). In Dallas County, more than 11.4% of the population has a diagnosis of Diabetes with more than 32% of the population classified as obese and at risk for developing Diabetes[275]. Traditionally, the underserved population does not have access to the necessary medications, education and supplies to manage their diabetes, thus many times patients go undiagnosed or have poor glucose control. This project would facilitate timely and appropriate care for those with diabetes and ensure that regular labs and point of care testing is completed to monitor results and make appropriate interventions. We expect that at least 5-7% of patients that are seen regularly in a Baylor Clinic will have improved HbA1c levels Bodenheimer, et al., found that patient self-management of chronic disease conditions, such as diabetes, that was co-located in a primary care setting led to significant improvement in HbA1c control in patients[276]. A recent of edition of Managed Care found that patients with an HbA1c > 9 had on average almost $5000 worth of hospitalization costs, while those with an HbA1c of < 7 had about $2700 in hospitalization costs[277]. Focusing efforts on increasing improvement of good glycemic control will result diminishing in other co-morbid conditions and improve complication rates for these patients. We expect that at least 5-7% of patients that are seen regularly in a Baylor Clinic will have improved HbA1c levels.

[274] http://www.diabetes.org/diabetes-basics/diabetes-statistics/
[275] RHP 9 Community Health Needs Assessment
[276] Bodenheimer, T., Lorig, K.., Holman, H., Grumbach, K. Patient Self-management of Chronic Disease in Primary Care *JAMA* (May 15, 2008).
[277] MenzinJ, Korn, J, Cohen, J, et.al Relationship between glycemic control and diabetes related hospital costs in patients with type 1 or type 1 diabetes mellitus. J Manag Care Pharm. 2010; 16(4):264-275.

Outcome Measure #2: T-1.11 Diabetes care: BP control (<140/80mm Hg) – NQF 0061 (**Standalone measure**). At Baylor Health Care System, blood pressure control and management is a required part of the diabetes care in order to avoid other co-morbid conditions such as heart disease and stroke. A 2010 study in the New England Journal of Medicine by Cushman, et al. showed that better and less severe health outcomes related to cardiovascular episodes and stroke were achieved with tight blood pressure control in diabetic patients[278]. Events that would be fatal with higher blood pressure became nonfatal under better blood pressure control in these studies completed. As part of an outpatient, clinic based protocol, blood pressure control can be achieved in patients who will come to the Baylor Clinic. Again, similar to HbA1c, we expect modest improvement in BP in years DY4 andDY5 contingent upon patient participation in the clinic and chronic disease program. Our primary goal will be to have patients come in for basic services and chronic disease education.

Outcome Measure #3: IT-1.13 Diabetes care Foot exam- NQF 0056 (**Non- standalone measure**).An innovative part of this project is that the educators (CHWs and RN Care Managers) will be able to conduct diabetic foot exams as part of their education session with their patients. This will increase the rate of screening and allow these providers to identify issues such as ulcers and nerve issues earlier and more often. Foot exams are a low cost, highly effective way to avoid costly interventions such as wound care and management, amputations,

Relationship to other Projects

139485012.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
This chronic care management project is related because: 1) services will be co-located and 2) the chronic care team will be integrated with the primary care team to facilitate complete care and efficiency for the patient.

139485012.2.3- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment
The project involving developing care management functions to integrate primary and behavioral health needs of individuals is related to this project of chronic care management because often times patients have co-occurring chronic disease and mental health issues which require attention. These programs can cross-refer depending on the patient's needs.

Related Category 4 Population-focused improvements

RD-1.1, RD-1.2, RD-1.4, RD-1.5, RD-2.1, RD-2.2, RD-2.4, RD-2.5, RD-2.7
RD-3.1, RD-3.2, RD-3.3, RD-3.4, RD-3.5, RD-3.6, RD-3.8, RD-3.10, RD-3.11, RD-3.12, RD-3.13, RD-3.14, RD-3.15, RD-3.24, RD-3.25, RD-3.26, RD-3.31

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Performing Provider	Unique Project	Project Option

[278] Cushman WC, Evans, GW, et al. Effects of intensive blood pressure control in type 2 diabetes mellitus. N Engl J Med. 2010. Apr 29; 362(17): 1575-85

Baylor University Medical Center	139485012.2.2	Expand Chronic Care Management Model – Diabetes (HbA1c poor control, BP control, foot exam)
Baylor Medical Center at Garland	121790303.2.2	
Baylor Medical Center at Irving	121776204.2.2	
Trinity Medical Center (Baylor-Carrollton)	195018001.2.1	
Children's Medical Center	138910807.1.3	Implement pediatric disease registry – asthma
Denton County HHS	13660803.2.1	Implement disease registry – diabetes
Methodist Charlton Medical Center	126679303.2.1	Expand Chronic Care Management Model – Diabetes (30-day readmission, Hba1c, BP control)
Methodist Dallas Medical Center	135032405.2.1	
Methodist Richardson Medical Center	209345201.2.1	
Parkland Health & Hospital System	127295703.1.3	Implement chronic care registry - Diabetes
Parkland Health &Hospital System	127295703.2.4	Chronic Care Management Model – Diabetes
Texas Health Presbyterian Hospital Denton	020967801.2.2	Chronic Care Management Model: Diabetes
Texas Health Presbyterian Hospital Kaufman	094140302.2.2	
UTSW – Faculty Practice Plan	126686802.2.2	Chronic Care Management Model - Diabetes

Plan for Learning Collaborative.

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor University Medical Center defined the population that will be directly impacted by the project as underserved patients who have Diabetes, Asthma, and/or CHF that are in need of education and treatment. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***3.*** We believe this to be the correct number because, when a person is positively impacted, she increases her ability to self-manage her illness(es) and maintain her health rather than relying on the physician or ED to manage her conditions. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***3.*** We believe this to be the correct number because, when a person is positively impacted, his propensity to understand his illness, share his knowledge with others and help spread health literacy

increases. Patients learn to manage their illnesses and escalations themselves rather than relying on expensive resources such as the ED.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

139485012.2.1	*2.2.2*	***PROJECT COMPONENTS: CQI***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Baylor University Medical Center				*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.9* *139485012.3.10* *139485012.3.11*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%) (**Standalone measure**)* *Diabetes care: BP control (<140/80mm Hg) (**Standalone measure**)* *Diabetes care Foot exam- (**Non- standalone measure**)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Develop a comprehensive care management program Metric 1 [P-3.1]: Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and the Institute of Chronic Illness Care's Assessment Model may be utilized in program development. Baseline/Goal: Determine exact care model to be used for CHF, Diabetes and COPD/Asthma patients Data Source: Documentation of plan and report showing detailed plans for addressing chronic disease education program Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 936,555 **Milestone 2** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1 [P-9.1]: Increase the	**Milestone 3** [P-2]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 [P-2.1]: Increase percent of staff trained Baseline/Goal: Train 100% of clinic staff on Chronic Care Model Data Source: Documentation of in-service or signed proclamation of education Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 681,154 **Milestone 4** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1 [P-9.1]: Increase the number of patients identified as needing screening test, preventative tests, or other clinical services Baseline/Goal: Compare patients with at least (1) or more chronic diseases from CHF, Diabetes, Asthma/COPD that have uncontrolled		**Milestone 6** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric 1 [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: At least 1461 unduplicated patients will be served by Chronic Care Management program over DY2 Data Source: E.H.R Metric 2 [I-21.4]: Improved compliance with recommended care regimens. Goal: 15% of patients in Chronic Care Management program (for at least 6 months) will have improved compliance with recommended regimens by the educators (non-physician regimens) Data Source: Patient survey,	**Milestone 7** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. The following metrics are suggested for use with an innovative project option but are not required. Metric 1 [I-21.2] : Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: At least 2073 unduplicated patients will be served by Chronic Care Management program over DY2 Data Source: E.H.R Metric 2 [I-21.4]: Improved compliance with recommended care regimens. Goal: 20% of patients in Chronic Care Management program (for at least 6 months) will have

139485012.2.1	*2.2.2*	***PROJECT COMPONENTS: CQI***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Baylor University Medical Center				*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.9* *139485012.3.10* *139485012.3.11*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%) (**Standalone measure**)* *Diabetes care: BP control (<140/80mm Hg) (**Standalone measure**)* *Diabetes care Foot exam- (**Non- standalone measure**)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
number of patients identified as needing screening test, preventative tests, or other clinical services Baseline/Goal: Determine current baseline of Baylor Clinic patients with at least (1) or more chronic diseases from CHF, Diabetes, Asthma/COPD that have uncontrolled clinical metrics Data Source: E.H.R., Report documenting current patients in need of Chronic Care Management program Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 936,555	clinical metrics over DY2 to determine prevalence of these chronic diseases at the Baylor Clinic Data Source: E.H.R, Report documenting DY3 patient needs Milestone 4 Estimated Incentive Payment: $ $ 681,154 **Milestone 5** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. <u>Metric 1</u> [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: At least 796 unduplicated patients will be served by Chronic Care Management program over DY2 Data Source: E.H.R <u>Metric 2</u> [I-21.4]: Improved compliance with recommended care regimens. Goal: 10% of patients in Chronic Care Management program (for at least 6		Educator Report /E.H.R Milestone 6 Estimated Incentive Payment: $ 2,049,403	improved compliance with recommended regimens by the educators (non-physician regimens) Data Source: Patient survey, Educator Report/E.H.R Milestone 7 Estimated Incentive Payment: $1,692,985

139485012.2.1	***2.2.2***	***PROJECT COMPONENTS: CQI***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Baylor University Medical Center				*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.9* *139485012.3.10* *139485012.3.11*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%) (**Standalone measure**)* *Diabetes care: BP control (<140/80mm Hg) (**Standalone measure**)* *Diabetes care Foot exam- (**Non- standalone measure**)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	months) will have improved compliance with recommended regimens by the educators (non-physician regimens) Data Source: Patient survey, Educator Report/E.H.R Milestone 5 Estimated Incentive Payment: $ 681,154			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,873,110	Year 3 Estimated Milestone Bundle Amount: $ 2,043,462		Year 4 Estimated Milestone Bundle Amount: $ 2,049,403	Year 5 Estimated Milestone Bundle Amount: $ 1,692,985
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 7,658,960				

Project Option 2.19.1 – Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals-Behavioral Health Counseling, Screening and Treatment

RHP Project Identifier: 139485012.2.2
Performing Provider Name/TPI: Baylor University Medical Center/139485012

Provider: Baylor University Medical Center at Dallas (Baylor Dallas) is a nationally recognized hospital that cares for more than 300,000 people each year. It is a major patient care, teaching and research center for the Southwest. Baylor Dallas has 1,065 licensed beds and serves as the flagship hospital of Baylor Health Care System. Located in Dallas, Baylor Dallas' service area represents a population of 4.2 million.

Intervention(s): This project will co-locate and integrate outpatient behavioral health services using an LCSW to provide counseling services. Screenings for depression, substance abuse and anxiety will also be an integral part of the program. This is a new project that has not been done before. It will serve the BH needs of the Uninsured/Medicaid population.

Need for the project: The RHP 9 Community Needs Health Assessment identified behavioral and mental health issues are a large unmet need in most counties within the region and also identified as the most difficult to access services in the Region. Behavioral Health issues are an identified impediment to clinical adherence and when addressed can create a material impact on clinical outcomes. Behavioral Health issues are especially prevalent in the underserved populations.

Target population: Underserved (Medicaid and uninsured) population in the Dallas area with behavioral health issues.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide screening and interventions to 2073 patients in the Dallas area. Approximately 85-90% of these patients will be Medicaid/Uninsured.

Category 3 outcomes: Category 3 outcomes for this project were chosen because: 1) the ambulatory setting of the project and 2) historical trends /literature based metrics that had material impact on patients in a 2-3 year time period.

- IT-11.1: Improvement in Clinical Indicator in Identified Disparity Group: Improvement in Diabetes Metrics (HbA1c, LDL, BP) for disparate group of uninsured/Medicaid patients with an underlying BH issue. Our goal is to have 5% of patients in DY3 achieve improvement in Diabetes Metrics (HbA1c, LDL BP), 10% in DY4 and 15% in DY5.
- IT-11.3: Improve utilization rates of clinical preventive services in target population with identified disparity: Improve utilization of BH services for patients who have been

screened/identified and diagnosed with an underlying BH issue. Disparate population is underserved population with BH issue. Our goal is to increase the patients who engage in BH treatment rates from 10% in DY3 to 20% in DY5.

Project Description

This project will co-locate and integrate behavioral health services into the outpatient primary care setting. The model that we aim to develop would consist of providing a LCSW to provide basic counseling services to address behavioral health needs such as: anxiety, depression, and substance abuse issues. The screening tools we plan to use are evidence based and will most likely include: PHQ2 or 9, GAD-7 and alcohol and substance abuse screeners. Additionally, the LCSW would have the support of a Community Health Worker (CHW) to help with the screening and referral processes. The training for the CHWs ,LCSWs and model development would occur at the Diabetes Health and Wellness Institute (Baylor entity in South Dallas) where the competencies and expertise would be created. From there, this staff can be triaged to clinics and community locations to provide behavioral health services. The behavioral health program would require that the LCSW and CHW to work together with the primary care team to: 1) identify the patients who have behavioral health issues, 2) coordinate the patient's care and appointments to fit both the behavioral health and primary care appointment in the same visit and 3) help the primary care team to identify those patients whose behavioral health issues are impeding the management of their acute/chronic disease management models. We anticipate that approximately 85-90% of these patients will be Medicaid/Uninsured.

Goals and Relationship to Regional Goals

The goals of this project are to increase the baseline of behavioral health services provided and screenings conducted to the underserved population in Dallas County received in an outpatient setting. By co-locating the behavioral health service with a patient's PCMH, we anticipate that compliance and adherence to attending behavioral health appointments will increase. Through increased screening, awareness and intervention, we also anticipate that behavioral health issues such as anxiety, depression and substance abuse will be proactively identified and addressed in order to allow the clinician and patient to focus on more acute/chronic illnesses that require protocol adherence. The derivative goal of this would also be to decrease ED visits related to behavioral health issues that are manageable in the outpatient setting. We believe by treating the underlying barriers associated with behavioral health, this will result in better health outcomes for this population. The RHP 9 Community Needs Health Assessment identified behavioral and mental health issues are a large unmet need in most counties within the region and also identified as the most difficult to access services in the Region. There were three regional priorities around behavioral health including integrating behavioral health with primary care and addressing behavioral health in other settings. More than 10% o f Dallas County residents "binge drink" and there are more than 10 deaths per 100,000 related to suicide[279]. Only 19% of patients receive behavioral health and primary care services in the same

[279] Healthy People North Texas: http://www.healthyntexas.org

setting[280]. The most compelling statistic is that 100% of the 10 most frequently admitted patients had a co-occurring behavioral health diagnosis. The aforementioned statistics make a strong and significant case that basic behavioral health services can achieve "quick wins" for this underserved population. This project is directly aligned with the Regional needs and is positioned to help facilitate care related to substance abuse, anxiety and depression[281].

Challenges

The challenges with behavioral health initiatives are that identification of patients and willingness of those patients to participate in a formal program do not coincide. There is a stigma associated with receiving counseling or behavioral health services which makes it difficult for providers to identify patients that have these underlying behavioral health issues and even more difficult for providers to get patients to come in for these types of appointments. In the community, patients do not see their behavioral health issues as a medical condition, thus the problems are often ignored and results in these patients using the ED for their acute behavioral health escalations. While this program would not focus on serious psychiatric issues such as schizophrenia or bipolar disorders, identifying depression or anxiety can have a significant impact on the patient's propensity to comply with medication and clinical recommendations/protocols. The way we plan to address the challenges mentioned above is through providing these services in a non-threatening way by individuals (CHWs/LCSWs) that come from the community they are serving. By using CHWs or LCSWs over physicians or other higher level providers, this should put the patient at ease. The program will also be presented in a counseling type environment rather than a psychiatric evaluation environment. Lastly, we will make behavioral health screenings a routine part of most primary care visits so that the assessments coincide with the patient's typical care.

5-year Expected Outcome for Provider and Patients

The 5 year expected outcome is that at least 20% of the total unduplicated patients (approximately 2073 patients) will receive behavioral health services at the Baylor Clinic. By identifying underlying behavioral health issues, acute and chronic medical issues can be addressed and compliance/adherence to clinical protocols should increase as well.

Starting Point/Baseline

There is no baseline for this project because there are no initiatives for behavioral health that are offered or ever have been at the Baylor Clinic located on the Baylor University Medical Center. This is a brand new program that will be administered to Clinic patients. We do know that the target population in the Dallas county area is over 200,000 underserved individuals who suffer from a mental illness. We calculated this number taking the uninsured population in Dallas County (872,000)[282] and a 2011 statistic taken from the Centers for Disease Control and Prevention that found 23% of uninsured patients suffer from a mental illness.[283]

[280] RHP 9 Community Health Needs Assessment

[281] Healthy People North Texas: http://www.healthyntexas.org

[282] http://quickfacts.census.gov/qfd/states/48/48439.html

[283] CDC: http://www.cdc.gov

Rationale

The reasons for selecting this project option are because behavioral health was not only identified as a major regional need, but Baylor Clinics have the infrastructure to effectively manage these types of issues within its PCMH framework. Many of our patients have underlying behavioral health issues which the physicians simply do not have time to address during a typical primary care visit, this model would allow patients to receive personalized attention for their behavioral health specific issues and allow the physicians to spend time on managing clinical issues. We believe by implementing a behavioral health component as part of the PCMH we have established, that patients will have improved overall health outcomes and providers will have greater satisfaction because these services will be performed by individuals who have an expertise in managing behavioral health issues. Lastly, we believe adding a behavioral health component to our primary care team will allow for cross communication between providers to understand all of the complex needs that are prevalent in this particular population.

Project Components

This behavioral health project has many components, all of which are addressed below:

a. Conduct data matching to identify individuals with co-occurring disorders who are:
    - not receiving routine primary care-*Patients who enter in to the behavioral health program will be automatically part of a PCMH*
    - not receiving specialty care according to professionally accepted practice guidelines: *We will be tracking this metric as part of our specialty care project- 1.9.2- Improving Access to Specialty Care*
    - over-utilizing ER services based on analysis of comparative data on other populations: *This is a metric that we already track and will continue to do so*
    - over-utilizing crisis response services. *This particular factor may be difficult to gather data on and is not typically a data point we collect*
    - Becoming involved with the criminal justice system due to uncontrolled/unmanaged symptoms. *This particular factor may be difficult to gather data on and is not typically a data point we collect*

b. Review chronic care management best practices such as Wagner's Chronic Care Model and select practices compatible with organizational readiness for adoption and implementation. *We plan to review the most effective models that address both chronic care and behavioral health to determine which model would easily address the intersection of both programs*

c. Identification of BH case managers and disease care managers to receive assignment of these individuals: We plan on hiring LCSWs and CHWs to act as BH care managers

d. Develop protocols for coordinating care; identify community resources and services available for supporting people with co-occurring disorders: As part of identifying which patients would be eligible and appropriate for this BH program, we will develop clinical protocols to identify patients and coordinate their care within the Baylor Clinic PCMH

e. Identify and implement specific disease management guidelines for high prevalence disorders, e.g. cardiovascular disease, diabetes, depression, asthma. *We plan to address this criteria through our Chronic Care Management project (2.2.1- Expand Chronic Care Management Models)*

f. Train staff in protocols and guidelines. *All staff will be made aware of this program and be trained on scheduling and identifying patients who could be part of this BH program*

g. Develop registries to track client outcomes. *We currently have a robust E.H.R in which we track other patient clinical metrics and measures, it would be redundant and inefficient to create a separate registry to track outcomes of this specific project. We intend to track outcomes in the current E.H.R.*

h. Review the intervention(s) impact on quality of care and integration of care and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations. *As part of our monthly review of project status, this will be included as will review of the other DSRIP projects the Baylor Clinic will be engaged in. We will focus on the key challenges associated with expansion and determine how and if the BH needs to be scaled to meet patient needs.*

Reasons for selecting outcome measures

The milestones and metrics chosen are focused on increasing volumes of patients seen. In order to be effective, patients will need to attend their appointments and be compliant with the recommended guidelines for their behavioral health issues and subsequent medical issues. In order to achieve the proposed metrics and milestones all of the other DSRIP projects will have to coordinate and synchronize in order to fulfill the metrics chosen. This will be advantageous to the Region, as it will create synergy and a complete plan of care for the patients in the target population. In the Planning Protocol, there were no options for Improvement Milestones that were directly applicable to this Behavioral Health program. Many of the metrics were focused on chronic disease, which we have an entire separate DSRIP project dedicated to. Thus, we created two customizable improvement milestones that focus on 1) increasing patient volumes (capturing eligible patients) and 2) improving rates of screening for anxiety, depression and substance abuse.

Unique community need identification number the project addresses:

CN.5- Behavioral Health ,CN.6-Behavioral Health and Primary Care

How the project significantly enhances an existing delivery system reform initiative
This project does not receive any federal funding and is a brand new initiative. There is currently no outpatient based behavioral health program offered to the underserved population at the Baylor Clinic at the Baylor University Medical Center. This project will provide a low cost, effective intervention to patients with behavioral health needs in a manageable setting for providers to identify potential escalation points related to behavioral health issues.

Related Category 3 Outcome Measures
Category 3 metrics for this project were identified using literature only. Baylor has no previous experience with a behavioral health program of this nature. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting.

Outcome Measure #1: IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (**Standalone measure**). We plan to measure the impact of diabetes management and control for patients who have enrolled in the proposed behavioral health program. A recent study conducted in early 2012, by Jeffery Johnson, et. al showed a direct correlation between diabetes and depression. They cited that depression is the most common co-morbid condition present in 15-30% of patients with Type 2 diabetes and less than 50% are recognized as having depression[284]. Depression is associated with poorer self-care behaviors, decreased quality of life and substantially higher health care costs. Both diabetes and behavioral health issues are prevalent across the region, warranting measurement of the efficacy of a behavioral health program on chronic diseases.

> Numerator: Number of patients with an improved Diabetes Percent of Opportunities Achieved (POA) improvement (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter
> Denominator: Total number of patients with a Behavioral Health intervention/encounter

Our Baylor Clinics currently track the Diabetes Percent of Opportunities Achieved (POA) for all patients with Diabetes. This is calculated by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population. POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in diabetes management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their diabetic patients than in the prior reporting period. For an illustrative example: For Diabetes- there are 3

[284] Johnson, JA, Sayah, FA, et.al. Controlled trial of a collaborative primary care team model for patients with diabetes and depression: rationale and design for a comprehensive evaluation. BMC Health Services Research. 2012, 12:358

opportunities (i.e. metrics) per patient (1) LDL < 100 (2) A1c < 8 and (3) BP < 130/80 mmHg. The denominator would be # of patients x 3. So, for example, if there are 10 patients x 3 opportunities each = 30 opportunities to be achieved. If, in the course of the year, only 20 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 20/30=67%. To achieve a 10% improvement in POA, we would have to have completed at least 23/30 opportunities to get at 76% achievement.

However, adding behavioral health as a subset of measurement for this patient population may change the actual improvement that is attainable. Because this is a new program, we do not have any historical data on the actual Diabetes improvement for those patients who receive a behavioral health intervention. We only have literature which has shown improvement in Diabetes with interventions related to depression. Thus, the improvement targets we have listed for Category 3 may differ as we implement the program.

Outcome Measure #2: IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (**Non-standalone measure**). We plan to focus on the treatment component of this metric, defining treatment as those patients who **engage** in the behavioral health program. We anticipate that patients who enter our Baylor Clinic and are identified as individuals who would benefit from a behavioral health intervention will have improved treatment and utilization rates.
Numerator: patients who are a Baylor Clinic patient and <u>engage</u> in behavioral health program
Denominator: patients who are a Baylor Clinic patient, <u>eligible</u> for behavioral health services
The idea of this metric is that by engaging patients in behavioral health treatment/interventions that their subsequent medical care will also improve. Patients who engage are those who have had at least two behavioral health interventions/encounters in the past 12 months. Patients eligible for behavioral health entail those that have 1) been identified through the PHQ2/9, GAD-7 and Substance Abuse screening tools that are in need of intervention, 2) self- identified need or 3) provider/clinician identification of patient need for behavioral health counseling. This Outcome Measure differs from our customized Improvement Milestone I-X: Target Population Reached: Increase Number of patients enrolled in BH program because the Improvement Milestone is focused on increasing volumes of eligible patients. Outcome measure 11.3 takes this one step further to ensure that the patient actually <u>engages</u> in the behavioral health program. By qualifying "engage" as a minimum of two interventions/encounters in the last 12 months, this varies from the Improvement Milestone of just increasing volume.

<u>Relationship to other Projects</u>
139485012.2.2- Expand Chronic Care Management Models- Create Chronic Disease management and Prevention Program. The Chronic Care Management Model project is related because if patients have a co-occurring behavioral health issue and chronic diseases, the services are co-located and patients can be referred into both programs if necessary.

139485012.1.1: Expand existing primary care capacity- Baylor Clinic Capacity Expansion

This behavioral health project is related to the expansion of primary care capacity project because 1) the services will be co-located and 2) the behavioral health team will be part of the overall primary care team; providing complete and efficient care for the patient.

Related Category 4 Population-focused improvements

Many of the behavioral health metrics listed Category 4 are much more intensive than the scope of the program. The intent of the program is to create a counseling mechanism by which underlying behavioral health issues can be addressed. We do anticipate that less severe disease states of mental illness will have decreased ED utilization and with behavioral health issues addressed a possible increase in the compliance to other services/protocols. Impacts to Category 4 include: RD-1.3, RD-1.7, RD-1.8, RD-1.1, RD-1.2, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.7, RD-3.36, RD-4.1, RD-4.2 RD-5.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Behavioral Health is pressing issue across the Region and will require collaboration and coordination between providers to manage these types of issues in a less costly, personalized setting. Our project differs from the two above because our focus is on counseling and screening. We will focus on disorders such as depression, anxiety and substance abuse.

Plan for Learning Collaborative.

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we priced our projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor University Medical Center defined the population that will be directly impacted by the project as the underserved PCMH Baylor Clinic patients with an underlying behavioral health issue(s). We used the pricing matrix developed by Regional providers to determine the value for each positive outcome. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a ***3.*** We believe this because, when a person is impacted, their compliance and adherence to clinical protocols increases, their satisfaction increases and self-management of their illnesses increases. To determine the value to the community, we concluded that, on a 1-5 scale, the value of this project is ***4.*** We

believe when a person is positively impacted, their productivity in the community increases as mentioned in the Community Health Needs Assessment where 25% of the population reported lost work days due to a mental health issue. In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

139485012.2.2	***2.19.1***	***2.19.1 (A-H)***	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS-*** *BEHAVIORAL HEALTH COUNSELING, SCREENING AND TREATMENT*	
Baylor University Medical Center				*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.12*	*3.IT-11.1*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider – Diabetes Improvement (**Standalone measure**)*	
	139485012.3.13	*3.IT-11.3*	*-Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity- BH Treatment Rate Improvement (**Non-standalone measure**)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Data matching is performed identifying service utilization patterns of people with co-occurring disorders and analysis conducted to identify over and under-utilization patterns. Metric 1 [P-4.1]: Data analysis report produced. Baseline/Goal: Determine number of patients with dual diagnosis- either self- identified or through previous medical history- to understand actual need in community Data Source: E.H.R/patient survey Milestone 1 Estimated Incentive Payment: $ 611,179 **Milestone 2** [P-5]: BH case managers and disease care managers are identified. Metric 1 [P-5.1]: Number of staff identified with the capacity to support the targeted population. Baseline/Goal: Hire 1 LCSW and 0.5 FTE of support staff (MA/POR) to handle case management of BH patients	**Milestone 4 [P-4]**: Data matching is performed identifying service utilization patterns of people with co-occurring disorders and analysis conducted to identify over and under- utilization patterns. Metric 1 [P-4.1]: Data analysis report produced. Baseline/Goal: Determine number of current patients that have a dual diagnosis and compare to DY 2 data collected Data Source: E.H.R/patient survey Milestone 4 Estimated Incentive Payment: $ 500,073 **Milestone 5** [P-6]: Care coordination protocols are developed. Metric 1 [P-6.1]: Written protocols are easily available to staff. Baseline/Goal: Educate 100% of clinic staff on BH protocols/standing order Data Source: Documentation of education completed through in-service sheets or signed documentation by staff Milestone 5 Estimated Incentive Payment:	**Milestone 8** [I-X]: Patient enrollment in program Metric 1 [I-X.1]: Target Population Reached: Increase Number of patients enrolled in BH program Goal: 1461 unduplicated patients will be identified and seen for a BH issue over DY2 Data Source: E.H.R Milestone 8 Estimated Incentive Payment: $ 1,003,053 **Milestone 9** [I-X]: Improve screening rates for depression, anxiety and substance abuse Metric 1 [I-X.1]: Short Term Outcomes: Improve % of patients screened with at least one BH tool Goal: 20% of all patients will be screened with PHQ2/9 or GAD-7 or Substance Abuse screening Data Source: E.H.R (% is t- he same to account for attrition in patient population) Milestone 9 Estimated Incentive Payment: $ 1,003,052	**Milestone 10** [I-X]: Patient engagement in BH program Metric 1 [I-X.1]: [I-X.1]: Target Population Reached: Increase Number of patients enrolled in BH program Goal:2073 unduplicated patients will be identified and seen for a BH issue over DY2 Data Source: E.H.R Milestone 10 Estimated Incentive Payment: $ 828,609 **Milestone 11 [I-X]**: I-X]: Improve screening rates for depression, anxiety and substance abuse Metric 1 [I-X.1]: Short Term Outcomes: Improve % of patients screened with at least one BH tool Goal: 25% of all patients will be screened with PHQ2/9 or GAD-7 or Substance Abuse screening Data Source: E.H.R (% is the same to account for attrition in patient population) Milestone 11 Estimated Incentive Payment: $ 828,608

139485012.2.2	***2.19.1***	***2.19.1 (A-H)***	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS-*** *BEHAVIORAL HEALTH COUNSELING, SCREENING AND TREATMENT*	
Baylor University Medical Center				*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.12* *139485012.3.13*	*3.IT-11.1* *3.IT-11.3*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider – Diabetes Improvement (**Standalone measure**)* *-Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity- BH Treatment Rate Improvement (**Non-standalone measure**)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Documentation Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 611,179 **Milestone 3** [P-6]: Care coordination protocols are developed. Metric 1 [P-6.1]: Written protocols are easily available to staff. Baseline/Goal: Develop protocols for identifying BH patients and protocols for making appointments. Ensure that executive physician committee signs off on protocols for LCSW. Data Source: Documentation of clinical protocols and processes Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 611,179	$ 500,073 **Milestone 6** [I-X]: Patient enrollment in program Metric 1 [I-X.1]: [I-X.1]: Target Population Reached: Increase Number of patients enrolled in BH program Goal: 796 unduplicated patients will be identified and seen for a BH issue over DY2 Data Source: E.H.R Milestone 6 Estimated Incentive Payment: $ 500,073 **Milestone 7** [I-X]: Improve screening rates for depression, anxiety and substance abuse Metric 1 [I-X.1]: Short Term Outcomes: Improve % of patients screened with at least one BH tool Goal: 15% of all clinic patients will be screened with PHQ2/9 or GAD-7 or Substance Abuse screening Data Source: E.H.R Milestone 7 Estimated Incentive Payment: $ 500,072		

139485012.2.2	***2.19.1***	***2.19.1 (A-H)***	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS-*** *BEHAVIORAL HEALTH COUNSELING, SCREENING AND TREATMENT*	
Baylor University Medical Center				*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.12* *139485012.3.13*	*3.IT-11.1* *3.IT-11.3*	*-Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider – Diabetes Improvement (**Standalone measure**)* *-Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity- BH Treatment Rate Improvement (**Non-standalone measure**)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount*:* $ 1,833,537	Year 3 Estimated Milestone Bundle Amount: $ 2,000,291		Year 4 Estimated Milestone Bundle Amount: $ 2,006,105	Year 5 Estimated Milestone Bundle Amount: $ 1,657,217
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 7,497,150				

Project Option 2.9.1 – Establish/Expand a Patient Navigation Program - Care Connect

RHP Project Identifier: 139485012.2.3
Performing Provider Name/TPI: Baylor University Medical Center/139485012

Provider: Baylor University Medical Center at Dallas (Baylor Dallas) is a nationally recognized hospital that cares for more than 300,000 people each year. It is a major patient care, teaching and research center for the Southwest. Baylor Dallas has 1,065 licensed beds and serves as the flagship hospital of Baylor Health Care System. Located in Dallas, Baylor Dallas' service area represents a population of 4.2 million.

Intervention(s): This project will identify and connect underserved patients in the hospital to a PCP/PCMH, create a multi-disciplinary care plan for frequently admitted patients and provide comprehensive follow up calls to patients to ensure they have an appointment and transportation to get to it.

New v. existing initiative: This project would be an expansion of Care Connect at Baylor University Medical Center. We will be adding additional staff to serve more Medicaid/ Uninsured patients add coverage on nights and weekends and create Care Plans for high risk patients.

Need for the project: Connecting patients to a PCP/PCMH will reduce ED utilization and provide outpatient services for complex patients. Over-utilization of the ED was identified as a Regional issue.
Target population: The 872,000 uninsured and Medicaid population in Dallas County without a PCP/PCMH who come to the ED. Approximately 85% of the new patients seen in the program will be Medicaid/Uninsured.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide access to an anticipated 7200 new patients from the community.

Category 3 outcomes: Category 3 outcomes for this project are from 2 different domains the true impact of this project is through ED appropriate utilization and cost savings. Both are priorities for the Region, which is why we felt we should show improvement in both areas.

- IT-5.1: Improved Cost Savings. Our goal is to increase cost savings of healthcare utilization (total cost of care in one year) of patients who have been connected to a PCP/PCMH appointment from 15% in DY3 to 25% in DY5. .

- IT-6.1: ED Appropriate Utilization. Our goal is to decrease all ED visits (including ACSC) from 25% in DY3 to 35% in DY5 and targeted conditions ED utilization (CHF, Diabetes, ESRD, CVD/Hypertension, BH/SA, COPD, Asthma) from 10% in DY3 to 20% in DY5. We

will be excluding pediatric emergency visits as part of this metric measurement because Baylor Univeristy Medical Center ED does not see a large volume of pediatric patients.

Project Description

This project aims to create a fluid care navigation program located at **Baylor University Medical Center** Emergency Department for patients (including Medicaid/Uninsured) who are identified (or proclaim) to not have a primary care physician and/or patient centered medical home to address their post-acute care needs. Approximately 85% of the new patients seen in the program will be Medicaid/Uninsured. By having staff physically located in these locations, patients can receive real time assistance in finding a provider and ensuring they are connected with the appropriate resources they would require once discharged home. We will include staff coverage on the weekends as well to ensure that patients are able to be seen and connected to resources 7 days/week. Additionally, in order to close the loop, staff will follow-up with patients to make sure they have an appointment and that they attend their appointment. The staff will also be responsible for ensuring that other barriers such as transportation are addressed and patients are able to attend their follow-up visits. The Care Connect staff will receive e-mail notifications any time a patient revisits the hospital, at this time staff will proactively visit with the patient to ensure the patient is able to access their PCP/PCMH appointment and/or recommended community resource(s). Care plans will be developed for patients with high hospital utilization (especially patients with frequent emergency department visits) and complex needs. Care plans will include involvement with Social Work Supervisor, Hospital Medical Director and other hospital staff. Patients with care plans will be contacted as often as needed to ensure continuity of the care plan.

Goals and Relationship to Regional Goals

The goals for this project are: 1) to connect a greater number of patients to a PCP/PCMH, 2) ensure the patients have the resources they need to care for themselves post discharge, 3) keep patients out of the ED and 4) create a care plan for high risk patients which ensures that the patient is receiving the follow-up care they need and are identified by staff when they readmit to the hospital

One of the major goals for the region is to reduce ED utilization and readmissions. This project focuses on and emphasizes both of these components. The entire impetus of the project is focused on Care Coordination and ensuring that patients are triaged to appropriate community and outpatient based resources. This is a strategy to decrease overall spending on health care in the region and help more patients connect to the essential primary care needed to maintain their health.

Challenges

Challenges with the underserved population almost always route back to the lack of continuity of care across the continuum. Because of their financial, time and resource constraints, this population often find a temporary fix to their health issue and once discharged from the hospital do not receive the care they need to stay healthy. If a patient is given an appointment

post discharge, they may have issues with transportation and other barriers that impede their access to care. Typically there is no follow-up to ensure the patient knows when their appointment is and if they actually went. This program aims to address these issues by identifying patients who do not have a PCP/PCMH, finding one for them, ensuring they have the resources they need to keep their appointment and then following up with the patient.

5-year Expected Outcome for Provider and Patients

The 5-year expected outcomes for this project include: 1) a minimum of 7200 patients connected to a PCP, PCMH or community resource, 2) 35% of these patients will have confirmed appointments within 14 days post-discharge. We expect that there will be fewer ED visits and readmissions for this population that was connected through this program and will experience overall improved health outcomes due to receiving appropriate and adequate post-acute care.

Starting Point/Baseline

The baseline for this project at Baylor University Medical Center is 386 patients served by the program from July 2012 to August 2012. The purpose of this project is to expand the scope and coverage of this project for more patients. We anticipate that the targeted population for the entire region is approximately 260,000 patients. This is calculated by taking the average rate of patients who are uninsured that do not have a PCMH/PCP (30%) multiplied by the total number of uninsured in Dallas (36% of the population).[285]

Rationale

We selected this project because it is a low cost, highly effective way to help promote the continuity of care for the underserved population. Utilizing CHWs and social work as the main staff involved in this project, these individuals are connected to the community and understand their complex needs. This project helps patients that do not have a PCP/PCMH connect to one and then also offers the continuous improvement piece that is often missing in these types of initiatives. We have seen demonstrated results in some of our other Baylor facilities that have shown reduced readmissions and lower ED utilization and we want to implement at Baylor University Medical Center. The other attractive components are the multidisciplinary care plans that will be developed for the highest risk patients to identify these individuals and hone in on triggers that cause them to (re)admit. We believe that this intervention is an effective way for staff to be involved with the patient at a grassroots level and allow patients to feel that they have someone responsible for ongoing care and navigation needs.

Project Components

This project has multiple components from the protocol including:

a. Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency: *This is a core part of our*

[285] http://quickfacts.census.gov/qfd/states/48/48439.html

program, we will be focusing on all ED patients that are identified to not have a PCP/PCMH. Our Care Plans are developed for patients who are frequent ED utilizers as well. Lastly, our CHWs that we will hirie come directly from the communities they serve so they understand the challenges/issues with patients that come from that community.

b. Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.*This project will primarily use CHWs and Social Workers to navigate patients and manage care.*

c. Connect patients to primary and preventive care. *The impetus of this program is focused on connecting patients to PCP/PCMH*

d. Increase access to care management and/or chronic care management, including education in chronic disease self-management. *Through connecting patients to a Baylor Clinic PCMH, these services for chronic care management will also be addressed.*

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. *This project will be part of an overall Baylor initiative that will be analyzing and evaluating the progress and challenges/barriers for all DSRIP projects. We will focus on identifying key challenges associated with the expansion and opportunities to scale the project where appropriate.*

Reasons for selecting outcome measures

The milestones and metrics that we chose are directly related to two of the goals identified by the region: 1) need for more care coordination and 2) overuse of ED services. The metrics we have in place increase the number of the target population served over the Waiver period and emphasize the connection rate to a PCP/PCMH. In addition, we have added a metric that creates regular reports that show comparative analyses year over year of the program. We believe by running detailed reports on what services were provided and how these coincide with the needs of the community, will allow for maximum effectiveness and positive outcomes of the project. These metrics directly impact the health and well-being of the patients served and ensure continuity in their care.

Unique community need identification number the project addresses:

CN.12- ED Usage and Readmissions

How the project significantly enhances an existing delivery system reform initiative

This project does not receive any federal funds and is a new initiative. It is focused on reducing high cost utilization of the ED setting and connects patients with a PCP/PCMH to avoid subsequent ED visits. This is a low cost, highly effective way to keep patients in appropriate care settings to manage their needs.

Related Category 3 Outcome Measures

The Standalone and Non-standalone metrics come from 2 different domains because the true impact of this project is through ED appropriate utilization and cost savings. Both are priorities for the Region, which is why we felt we should show improvement in both areas.

Outcome Measure #1: IT-9.2 ED appropriate utilization (**Standalone measure**). According to the Community Health Needs Assessment of Region 9, 68% of the ED visits in the region were for non-emergent situations that could have been handled in the primary care/outpatient settings. This metric is at the heart of the care navigation project we are proposing and will have a direct impact on patients in Dallas County utilizing the ED at a decreased rate. This project uses the popular concept created by Dr. Atul Gawande, referred to as "hot spotting" indicating a focus on finding the high risk/high utilization rates of the ED and determining the root cause for these visits, and then working to remedy those issues. Issues such as transportation, navigation of community and appropriate resources are just two examples that can lead to more effective use of the ED.[286]

Outcome Measure #2: IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (**Non- standalone measure).** Financial constraints are a main concern for the Region in being able to provide high quality care to the underserved population. Cost savings and effectiveness are a key part of the overall Waiver and require providers to be good stewards of their resources. This metric is appropriate because it emphasizes appropriate utilization of resources and reinforces the concept of cost effectiveness. We plan to measure the cost effectiveness and cost utilization of this project. According to the Texas Medical Association, the cost of treating a condition that could be treated in the doctor's office for $56.21 (including lab and x-ray) costs $193.92 in the Emergency room[287]. This cost differential multiplied by the 443,000 uninsured in Dallas County creates a significant cost to the county and Region. On a more global level, AHRQ found that the average cost in 2006 for an uninsured patient stay in the hospital cost about $19,400. There is definite room for opportunity to produce cost savings for this population.[288]

Relationship to other Projects

139485012.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

The navigation program is located in the hospital and will facilitate the connection of patients to the Baylor Clinic that are identified by the staff to not have a PCP/PCMH.

[286] Gawande, A. The hot spotters: can we lower medical costs by giving the neediest patients better care? The New Yorker. (2011).

[287] Texas Medical Association: http://www.texmed.org

[288] AHRQ: http://www.ahrq.gov

Category 4 Population-focused improvements

RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.7, RD-1.8, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7, RD-4.1, RD-4.2, RD-5.1

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Care Coordination models require an initial connection but also require resources to triage patients to. Once a patient is identified to need a PCP/PCMH or another community resource, it becomes the Region's responsibility to ensure there are outlets for these patients to receive the care they need. Care Navigation programs serve the patients located in the specific EDs/inpatient units of the performing providers and thus do not duplicate patients on a per visit basis. While our geographies overlap, these programs are localized to individual hospitals. The 12 projects in RHP 9 to enhance patient navigation programs include the following:

Performing Provider	Unique Project Number
Baylor Medical Center at Garland	121790303.2.3
Baylor Medical Center at Irving	121776204.2.3
Children's Medical Center	138910807.2.3
Medical Center of Lewisville (HCA)	094192402.2.3
Methodist Charlton Medical Center	126679303.2.2
Methodist Dallas Medical Center	135032405.2.1
Methodist Richardson Medical Center	209345201.2.1
Parkland Health & Hospital System	127295703.2.7
Texas Health Presbyterian – Denton	020967801.2.1
Texas Health Presbyterian – Kaufman	094140302.2.1
University of Texas Southwestern – Faculty	126686802.2.4
University of Texas Southwestern – Hospital	175287501.2.1

Plan for Learning Collaborative.

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 3 Regional Healthcare Partnerships. In order to be consistent in our valuation methodology, we have used the same process and technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced our projects and outcomes by computing the total value of the Category 3 outcomes connected to each project.

Baylor University Medical Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. ***Baylor University Medical Center*** defined the population that will be directly impacted by the project as the underserved/uninsured patients that do not have a PCP/PCMH that present in our ***Baylor University Medical Center*** *ED or inpatient units.* We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3. We believe this to be the correct number because, when a person is connected to community and primary care resources, they can find ways to manage their illnesses on a daily basis and have a contact for their care needs. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a *4.* We believe this to be the correct number because, when a person is positively impacted, their ED utilization decreases, community resource burdens are relieved and a greater number of people have a PCMH.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

139485012.2.3	***2.9.1***	***2.9.1.(A-E)***	***ESTABLISH/EXPAND A CARE NAVIGATION PROGRAM-*** *CARE CONNECT*
Baylor University Medical Center			*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.14* *139485012.3.15*	*3.IT-5.1* *3.IT-9.2*	*Improved cost savings: Demonstrate cost savings in care delivery* ***(Non-Standalone)*** *ED appropriate utilization (****Standalone measure****)*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-2]: 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: Hire appropriate staff- at least 2 FTEs Data Source: Documentation of employment Metric 2 [P-2.2]: Number of unique patients enrolled in the patient navigation program; Baseline/Goal: Establish baseline of patients seen in DY2 Data Source: E.H.R./Navigation database Metric 3 [P-2.3]:	**Milestone 3** [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. Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided Baseline/Goal: Provide completed report to compare types of navigation offered in DY2 v. DY3 Data Source: E.H.R/Navigation notes and database Milestone 3 Estimated Incentive Payment: $ 971,364 **Milestone 4** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric 1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care	**Milestone 5** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric 1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care referrals to at least 40% of patients identified by care navigation program Data Source: E.H.R./Patient Navigation program database Metric 2 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Identify at least 2400 patients Data Source: E.H.R./Patient Navigation program database Milestone 5 Estimated Incentive Payment: $1,948,376	**Milestone 6** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care referrals to at least 50% of patients identified by care navigation program Data Source: E.H.R./Patient Navigation program database Metric 2 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Identify at least 2880 patients Data Source: E.H.R./Patient Navigation program database Milestone 6 Estimated Incentive Payment: $ 1,609,528

139485012.2.3	***2.9.1***	***2.9.1.(A-E)***	***ESTABLISH/EXPAND A CARE NAVIGATION PROGRAM-*** *CARE CONNECT*
Baylor University Medical Center			*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.14* *139485012.3.15*	*3.IT-5.1* *3.IT-9.2*	*Improved cost savings: Demonstrate cost savings in care delivery* ***(Non-Standalone)*** *ED appropriate utilization (****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)**
Frequency of contact with care navigators for high risk patients. Baseline/Goal: Track frequency of patient contact with navigator while in ED setting Data Source: E.H.R./Patient Navigation program database Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 890,387 **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. <u>Metric 1</u> [P-5.1]: Collect and report on all the types of patient navigator services provided Baseline/Goal: Create report format and educate navigators about data points to be collected Data Source: Documentation of report created Milestone 2 Estimated Incentive	referrals to at least 30% of patients identified by the navigation program Data Source: E.H.R./Patient Navigation program database <u>Metric 2</u> [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Identify at least 1920 patients Data Source: E.H.R./Patient Navigation program database Milestone 4 Estimated Incentive Payment: $ 971,364		

139485012.2.3	***2.9.1***	***2.9.1.(A-E)***	***ESTABLISH/EXPAND A CARE NAVIGATION PROGRAM-*** *CARE CONNECT*
Baylor University Medical Center			*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.14* *139485012.3.15*	*3.IT-5.1* *3.IT-9.2*	*Improved cost savings: Demonstrate cost savings in care delivery* ***(Non-Standalone)*** *ED appropriate utilization (****Standalone measure****)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Payment *(maximum amount):* $ 890,386			
Year 2 Estimated Milestone Bundle Amount: $ 1,780,773	Year 3 Estimated Milestone Bundle Amount: $ 1,942,728	Year 4 Estimated Milestone Bundle Amount: $1,948,376	Year 5 Estimated Milestone Bundle Amount: $ 1,609,528
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 7,281,405			

Project Option 2.12.2 – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs - Vulnerable Patient Network (Home Visit Program)

RHP Project Identifier: 139485012.2.4 – Pass 2
Performing Provider Name/TPI: Baylor University Medical Center/139485012

Provider: Baylor University Medical Center at Dallas (Baylor Dallas) is a nationally recognized hospital that cares for more than 300,000 people each year. Baylor Dallas has 1,065 licensed beds and serves as the flagship hospital of Baylor Health Care System. Located in Dallas, Baylor Dallas' service area represents a population of 4.2 million.

Intervention(s): This project will provide in-home visits to the highest risk uninsured and Medicaid patients. Risk is defined by patient propensity of complications, (re)admissions, downstream healthcare utilization and costs within the parameters of socioeconomic and clinical risk indicators. The team will be led by an APRN overseen by a Medical Director and augmented with a Social Worker, LVN and Care Coordinator who will have overall oversight and responsibility of continuity of care for the patients in the program. Services such as examinations and clinical decision making to changing urinary catheters, labs, vaccinations and medication reconciliation, management and education will be available in the patient's home. This project is an expansion of the Vulnerable Patient Network at Baylor University Medical Center. New components include an expanded care team, risk stratification and identification of high risk patients, complete oversight and management of program patients and increased contact encounters with patients in their homes.

Need for the project: High risk and complex patients that need intensive management will receive care in their homes to address acute and chronic needs. This should facilitate fewer visits to the ED, greater compliance to clinical protocols and regimens and create improved quality outcomes.

Target population: The top 5% highest risk patients of the 872,000 uninsured and Medicaid population in Dallas County that have at least one of the following characteristics: homebound, disabled, multiple chronic diseases, polypharmacy or any other medical or social conditions limiting the patients' ability to access care in an ambulatory care setting.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide care to 100 high risk patients.

Category 3 outcomes: Category 3 outcomes for this project focus on identifying and improving impediments to patient care in order to increase compliance and better outcomes.

- IT-10.1: Quality of Life. Our goal is to increase mean score (from time of enrollment to current survey) on QOL assessments by 7% by DY5 for patients in program for at least 6 months.

- IT-10.2: Activities of Daily Living. Our goal is to increase the mean score (from time of enrollment to current survey) on ADL assessments by 7% by DY5 for patients in the program for at least 6 months.

Project Description

The Vulnerable Patient Network (VPN) program provides home visits to the highest risk (clinically, economically and socially) and vulnerable Medicaid and uninsured patients. Using a combination of the Hot Spotting model developed by Dr. Jeffery Brenner of the Camden Coalition of Healthcare Providers[289] and a validated risk stratification tool, we will stratify and identify the top 5% of high risk patients in the Medicaid and Uninsured population. Qualifiers for enrollment in this program include patient characteristics that include but are not limited to: homebound, disabled, multiple chronic diseases, polypharmacy or any other medical or social conditions limiting the patients' ability to access care in an ambulatory care setting. A multidisciplinary team comprised of an advanced nurse practitioner (APRN) and LVN to see patients in the home and provide acute, primary and chronic care. In addition, social workers will be part of the team to address barriers to care and any social issues. Care Coordinators will also be part of this team to facilitate coordination and continuity of care for patients and have high level oversight for patients; bringing together the necessary components of care for these complex patients. Lastly, a Medical Director will have management over the entire project. A full spectrum of services will be available in the patient home ranging from examinations and clinical decision making to changing urinary catheters, labs, vaccinations and medication reconciliation, management and education.

Goals and Relationship to Regional Goals

The goals for this project are: 1) Increase patients who receive primary care, 2) Overcome access issues for high risk patients, 3) Address acute care issues in the patient's home rather than the Emergency Department, 4) Increase patient compliance and adherence to regimens, 5) Decrease barriers to care around receiving medications and overall care, 6) Increase contact rate with provider for high risk patients and 7) Increase medication reconciliation frequency.

Two of the goals for the region include increasing healthcare capacity and decreasing ED utilization and readmissions. This project increases access to care for those high risk patients who are unable or unwilling to be seen in primary care office. It creates additional points of care for patients to receive care and improve compliance and clinical outcomes. Patients who have multiple chronic diseases and unable to go to appointments can have their conditions proactively managed in their homes. Together long term disease management and avoidance

[289] Gawande, A. "The hot spotters." *The New Yorker*, January 24, 2011.

of exacerbations lead to better clinical outcomes, lower ED utilization, lower costs and better overall patient health. According to the Community Needs Assessment, the conditions with the highest ED visit volumes for the Medicaid and uninsured population were: diabetes, CHF and stroke. With proper and consistent management, these conditions are manageable.[290] The top 10 utilizers of health care services in the region accumulated $26 million in costs.[291] These patients would be candidates for this Home Visit program, identifying them through the "hot spotting" methodology[292] and proactively managing their conditions. This program will help to improve outcomes of chronic diseases and related complications by proactively managing the patient in a setting that is convenient and comfortable for them, hopefully increasing compliance to treatment protocols and medication adherence.

Challenges

High risk (clinical and socioeconomic) uninsured and underinsured patients often have multiple co-morbidities, issues with access and lack of resources to care for themselves. These patients, due to financial and other constraints cannot afford medications, transportation to appointments and may be physically incapable of leaving their homes to receive care. These are the patients that end up having their clinical conditions escalate and end up in the Emergency Department because the lack of adequate and timely primary care. This program would remove barriers to access by providing a full range of clinical and social services high risk patients need in their homes. This also allows the care team to physically survey the patient's living conditions and find inhibitors to help the patient overcome these issues to better care of themselves.

5-year Expected Outcome for Provider and Patients

The 5-year expected outcomes for this project include: 1) provide home care to a minimum of 100 patients, 2) improve mean quality of life scores by a 7% over baseline for patients enrolled in VPN for at least 6 months, 3) improve Activities of Daily Living mean scores by 7% over baseline for patient enrolled in VPN for at least 6 months and create a robust, multidisciplinary care team that manages everything for the patient from scheduling appointments, receiving labs/medications to addressing social issues and helping the patient to overcome barriers to care. We expect that ED and inpatient utilization will decrease and this cohort of high risk patients will have improved clinical outcomes and fewer downstream disease complications/issues.

<u>Starting Point/Baseline</u>

The baseline for this project at Baylor University Medical Center has not been rigorously tracked. Approximately 90 patients have been seen over the past 2 years. On average, patients remain in the program for 298 days. Currently, the patient panel for the program includes Medicare patients who, under this project will be transitioned to a different service. Although this project is an extension of the current program Baylor University Medical Center has in

[290] RHP 9 Community Health Needs Assessment

[291] RHP 9 Community Health Needs Assessment.

[292] Gawande, A. "The hot spotters." *The New Yorker*, January 24, 2011

place, it has many new components (expanded care team, more services, greater frequency of visits, focus on Medicaid and Uninsured, etc).

Rationale

We selected this project because in the populations we serve, many times patients are unable or unwilling to come to the Baylor Clinic to receive the care they need. The Medicaid and uninsured populations have multiple social, economic and other barriers on top of clinical issues that prevent them from appropriately managing their health. This project uses a face to face mechanism whereby patients are monitored regularly and have all of their needs met in a venue that is convenient and comfortable for them. In a recent article in Health Affairs, entitled Six Features of Medicare coordinated care demonstration programs that cut hospital admissions of high risk patients, Brown found supplementing telephone calls to patients with frequent in-person meetings; occasionally meeting in person with providers; acting as a communications hub for providers; delivering evidence-based education to patients; providing strong medication management; and providing timely and comprehensive transitional care after hospitalizations were characteristics of successful care coordination programs.[293] Our project, the Vulnerable Patient Network incorporates these components into the program and furthers them by adding additional services such examinations and clinical decision making to changing urinary catheters, labs, vaccinations. The team we propose to put in place would be able to address all of these needs in a coordinated and fluid fashion.

Project Components

This project has no required project components. We do plan to engage in continuous quality improvement activities such as: identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Reasons for selecting outcome measures

The milestones and metrics we chose for this project are focused on identifying and intervening on high risk patients who are high utilizers of healthcare services and are unable or unwilling to receive care in an ambulatory care setting. There is one point of clarification needed around the target population for this project. We define the target population as the following:

- Numerator: The number of patients enrolled in the program
- Denominator: The number of patients referred from the hospital as identified by Care Coordinators/Navigators as possible candidates based on identified risk factors including but not limited to: homebound, disabled, multiple chronic diseases, polypharmacy or

[293] Brown, RS. Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high risk patients. *Health Aff*. 2012 June; 21(6): 1156-1165.

any other medical or social conditions limiting patients' ability to access care in ambulatory care setting

The reason we selected outcome measures related to Quality of Life and Activities of Daily living was in order to emphasize the importance for the Care Team to identify and assess non-clinical barriers that may be impeding the patient from receiving the optimal level of care necessary to maintain and sustain their health status.

Unique community need identification number the project addresses:
CN.3- Healthcare Capacity and CN.12 Emergency Department Usage and Readmissions

How the project significantly enhances an existing delivery system reform initiative
This project does not receive any federal funds and is a new initiative. It is focused on addressing the complex needs of the highest risk patients by bringing care into their homes.

Related Category 3 Outcome Measures
The Category 3 Outcomes chosen for this project are based upon expected improvement for quality of life and activities of daily living. Many of the components included in Quality of Life and Activities of Daily living assessments help the care team to identify barriers to care and increase compliance. Both measures would also help to periodically and regularly assess QOL and ADL measures to keep an updated record of the patient's barriers to care.

Outcome Measure #1: IT-10.1 Quality of Life (**Standalone measure**).
Quality of Life assessments such as the SF-36 or AQoL measure components such as: illness, independent living, social relationships, physical senses and psychological wellbeing and will be important to measure in the high risk and vulnerable patients we intend to serve.[294] Understanding social and physical attributes of the patient will be essential in determining their feasibility of following protocols and regimens that will optimize their healthcare. We plan on conducting a QOL assessment every 6 months on patients who have been in the program for at least 6 months. Improvement will be measured from the time the patient is enrolled to time of survey administration.

Outcome Measure #2: IT-10.2 Activities of Daily Living (**Standalone measure**).
Measurement of the activities of daily living is critical because they have been found to be significant predictors of paid home care , use of hospital services, living arrangements, use of physician, insurance coverage and mortality.[295] While ADLs are typically used with the elderly population, the complexity and nature of the high risk uninsured/Medicaid patients warrants this assessment as well. Monitoring the progress or decline of factors such as bathing, feeding, continence, transferring, toileting and dressing are immediate predictors of any issues or

[294] Hawthorne, G. The assessment of quality of life instrument: a psychometric measure of health related quality of life. *Qual Life Res.*8(3):209-24 (1999)
[295] Measuring ADLs Across National Surveys: http://aspe.hhs.gov/daltcp/reports/meacmpes.htm

barriers that patients may be experiencing.[296] We may need to consider using the Lawton IADL scale for this population as it involves more complex activities such as: shopping, laundry, responsibility for own medications, etc.[297] We plan on conducting the ADL assessment every 6 months and patients that have been in the program for 6 months. The improvement will be measured from the time that patients enroll in the program to survey conduction.

Relationship to other Projects

139485012.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
Patients that are in the Vulnerable Patient Network can come from the Baylor Clinic. Patients that are identified as high risk from the Baylor Clinic are candidates for the VPN program.

Category 4 Population-focused improvements

RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.7, RD-1.8, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7, RD-4.1, RD-4.2

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

Care Coordination models require an initial connection but also require resources to triage patients to. Once a patient is identified to need a PCP/PCMH or another community resource, it becomes the Region's responsibility to ensure there are outlets for these patients to receive the care they need.

Performing Provider	Unique Project Number
Baylor Medical Center at Garland	121790303.2.4
Baylor Medical Center at Irving	121776204.2.4
Children's Medical Center	138910807.2.4
Doctors Hospital at White Rock (Tenet)	094194002.2.2
Parkland Health & Hospital System	127295703.2.9
University of Texas Southwestern – Faculty	126686802.2.5
University of Texas Southwestern – Hospital	175287501.2.3

Plan for Learning Collaborative. We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

[296] Katz, Sidney. 1983. "Assessing Self-Maintenance: Activities of Daily Living, Mobility, and Instrumental Activities of Daily Living." *Journal of the American Geriatrics Association* 31:721-727.
[297] Lawton, M. Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living. *The Gerontologist* 9:179-186.

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced our projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. That model computes separate values for impacts on the health care system, the individual and the community. ***Baylor University Medical Center*** defined the population that will be directly impacted by the project as the underserved/ uninsured patients are considered high risk both clinically and socioeconomically. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 4. We believe when a person is connected to comprehensive care, available to them in their homes, compliance and outcomes both improve. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a *3.* We believe when a person is positively impacted, their ED utilization decreases, community resource burdens are relieved and a greater number of people receive care. In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

139485012.2.4	***2.12.2***	***CQI***	***IMPLEMENT PILOT INTERVENTION IN CARE TRANSITIONS-*** *VULNERABLE PATIENT NETWORK (VPN)*	
Baylor University Medical Center				*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.16* *139485012.3.17*	*3.IT-10.1* *3.IT-10.2*	*Quality of Life (**Standalone measure**)* *Activities of Daily Living (**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-5]: Using a validated risk assessment tool, create a patient identification system Metric 1 [P-5.1]: Patient stratification system Baseline/Goal: Develop and validate risk assessment tool Data Source: Documentation tool options and assessments Milestone 1 Estimated Incentive Payment *(maximum amount):* $562,791 **Milestone 2** [P-7]: Develop a staffing and implementation plan to complete goals/objectives of the care transitions program Metric 1 [P-7.1]: Documentation of staffing plan Baseline/Goal: Create staffing plan for care team Data Source: Staffing and implementation plan Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 562,790	**Milestone 3** [P-5]: Using a validated risk assessment tool, create a patient identification system Metric 1 [P-5.1]: Patient stratification system Goal: Implement risk assessment tool Data Source: Submission of risk assessment tool and patient stratification report and description of provider utilization report of findings Milestone 3 Estimated Incentive Payment: $409,316 **Milestone 4** [P-9]: Implement a case management related registry Metric 1 [P-9.1]: Documentation of registry implementation Goal: Implement and validate registry Data Source: Registry reports demonstrating case management functionality Milestone 4 Estimated Incentive Payment: $409,316		**Milestone 6** [I-15]: Improve care transitions using innovative project option Metric 1 [I-15.1]: Increase percentage of target population reached Goal: Increase percentage of target population reached by 25% (or minimum of 65 patients over baseline) Numerator: Number of patients enrolled in intervention Denominator: Number of patients referred from the hospital as potential candidates based on risk factors Data Source: Documentation of target population reached Metric 2 [I-15.2]: Evaluate the intervention(s) Goal: Report number of patients transitioned by type of transition Data Source: data file of all transitioned patient in one year Metric 3 [I-15.3]: Percentage of patients, regardless of age discharged from an inpatient facility to home or any other site of care for whom a transition record was	**Milestone 7** [I-15]: Improve care transitions using innovative project option Metric 1 [I-15.1]: Increase percentage of target population reached Goal: Increase percentage of target population reached by 35% (or minimum of 100 patients over baseline) Numerator: Number of patients enrolled in intervention Denominator: Number of patients referred from the hospital as potential candidates based on risk factors Data Source: Documentation of target population reached Metric 2 [I-15.2]: Evaluate the intervention(s) Goal: Report number of patients transitioned by type of transition Data Source: data file of all transitioned patient in one year Metric 3 [I-15.3]: Percentage of patients, regardless of age discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary care physician or other health care professional designated for follow-up within 24 hours of discharge Goal: Report percentage of patients for

139485012.2.4	***2.12.2***	***CQI***	***IMPLEMENT PILOT INTERVENTION IN CARE TRANSITIONS-*** *VULNERABLE PATIENT NETWORK (VPN)*	
Baylor University Medical Center				*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.16* *139485012.3.17*	*3.IT-10.1* *3.IT-10.2*	*Quality of Life (**Standalone measure**)* *Activities of Daily Living (**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 5 [I-15]: Improve care transitions using innovative project option Metric 1 [I-15.1]: Increase percentage of target population reached Goal: Increase percentage of target population reached by 15% (or minimum of 30 patients over baseline) Numerator: Number of patients enrolled in intervention Denominator: Number of patients referred from the hospital as potential candidates based on risk factors Data Source: Documentation of target population reached Metric 2 [I-15.2]: Evaluate the intervention(s) Goal: Report number of patients transitioned by type of transition Data Source: data file of all transitioned patient in one year Metric 3 [I-15.3]: Percentage of patients, regardless of age	transmitted to the facility or primary care physician or other health care professional designated for follow-up within 24 hours of discharge Goal: Report percentage of patients for whom a transition record was transmitted to a facility or primary care of other health care professional designated for follow-up within 24 hours of discharge Data Source: data file of all transitioned patient in one year Metric 4 [I-15.4]: Percentage of patients regardless of age, discharged from an emergency department to ambulatory care or home health, or their caregiver, who received a transition record at the time of ED discharge Goal: Report number of patients who received a transition record at the time of ED discharge including: major procedures and tests performed during ED visit, principal diagnosis (or chief complaint), patient instructions, plan for follow up care (or statement that none was required), list of new medications and changes to continued medications that patient should take after ED discharge	whom a transition record was transmitted to a facility or primary care of other health care professional designated for follow-up within 24 hours of discharge Data Source: data file of all transitioned patient in one year Metric 4 [I-15.4]: Percentage of patients regardless of age, discharged from an emergency department to ambulatory care or home health, or their caregiver, who received a transition record at the time of ED discharge Goal: Report number of patients who received a transition record at the time of ED discharge including: major procedures and tests performed during ED visit, principal diagnosis (or chief complaint), patient instructions, plan for follow up care (or statement that none was required), list of new medications and changes to continued medications that patient should take after ED discharge Data Source: EHR Milestone 7 Estimated Incentive Payment: $1,017,341

139485012.2.4	***2.12.2***	***CQI***	***IMPLEMENT PILOT INTERVENTION IN CARE TRANSITIONS-*** *VULNERABLE PATIENT NETWORK (VPN)*	
Baylor University Medical Center				*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.16* *139485012.3.17*	*3.IT-10.1* *3.IT-10.2*	*Quality of Life (**Standalone measure**)* *Activities of Daily Living (**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)**
	discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary care physician or other health care professional designated for follow-up within 24 hours of discharge Goal: Report percentage of patients for whom a transition record was transmitted to a facility or primary care of other health care professional designated for follow-up within 24 hours of discharge Data Source: data file of all transitioned patient in one year Metric 4 [I-15.4]: Percentage of patients regardless of age, discharged from an emergency department to ambulatory care or home health, or their caregiver, who received a transition record at the time of ED discharge Goal: Report number of patients who received a transition record at the time of ED discharge including: major procedures and tests performed during ED visit, principal diagnosis (or chief complaint), patient instructions, plan for follow up care (or statement that none was required), list of new medications		Data Source: EHR Milestone 6 Estimated Incentive Payment: $1,231,518	

139485012.2.4	***2.12.2***	***CQI***	***IMPLEMENT PILOT INTERVENTION IN CARE TRANSITIONS-*** *VULNERABLE PATIENT NETWORK (VPN)*	
Baylor University Medical Center				*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.16* *139485012.3.17*	*3.IT-10.1* *3.IT-10.2*	*Quality of Life (**Standalone measure**)* *Activities of Daily Living (**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)**
	and changes to continued medications that patient should take after ED discharge Data Source: EHR Milestone 5 Estimated Incentive Payment: $409,316			
Year 2 Estimated Milestone Bundle Amount*:* $ 1,125,581	Year 3 Estimated Milestone Bundle Amount: $1,227,948		Year 4 Estimated Milestone Bundle Amount: $1,231,518	Year 5 Estimated Milestone Bundle Amount: $1,017,341
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**: $4,602,388*				

Project Option 2.11.3 – Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

RHP Project Identifier: 139485012.2.5 – Pass 2
Performing Provider Name/TPI: Baylor University Medical Center/139485012

Provider: Baylor University Medical Center at Dallas (Baylor Dallas) is a nationally recognized hospital that cares for more than 300,000 people each year. Baylor Dallas has 1,065 licensed beds and serves as the flagship hospital of Baylor Health Care System. Located in Dallas, Baylor Dallas' service area represents a population of 4.2 million.

Intervention(s): This project will provide medication management and reconciliation services to uninsured and Medicaid patients at the Baylor Clinic on the Baylor University Medical Center campus. Patients who are 150% or below the FPL and/or have chronic illnesses can qualify for prescription assistance. A clinical pharmacist will be responsible for oversight of prescriptions, educate patients about how and why to take their medications and review utilization, appropriateness and efficacy of medications that patients have been prescribed. This project is a new initiative and contributes to creating a complete PCMH for underserved patients.

Need for the project: Non-compliance to medications can lead to complications and clinical exacerbations that are often avoidable with proper management and education. Medications are an important part of a patient's care regimen but can become an impediment to care when issues such as access or cost become prevalent. This project will help to overcome these issues.

Target population: Baylor Clinic patients who have multiple medications, chronic diseases and/or have demonstrated need for prescription assistance. At least 90% of patients served will be Uninsured/Medicaid.

Category 1 or 2 expected patient benefits: From DY3-DY5 the project will provide medication management to 480 patients.

Category 3 outcomes: Category 3 outcomes for this project do not have any baseline data and improvements are based on ranges of current performance.

- **IT-1.2** Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs (Non-standalone measure). Our goal is to increase the appropriate monitoring tests from at least 2% in DY3 to at least 6% in DY5.
- **IT-1.4** Annual monitoring for patients on persistent medications– diuretic (Non-standalone measure). Our goal is to increase the appropriate monitoring tests from at least 2% in DY3 to at least 6% in DY5.

- **IT-1.5** Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)**.** Our goal is to increase the appropriate monitoring tests from at least 2% in DY3 to at least 6% in DY5.
- **IT-1.19** Antidepressant Medication Management - (Standalone measure). Our goal is to increase effective acute phase treatment by 5% in DY3 to 15% in DY5 and to increase continuous phase treatment by 3% in DY3 to 7% in DY5.

Project Description

This project option combines project options 2.11.1- Implement interventions that put in place teams, technology and processes to avoid medication errors and 2.11.2- Evidence based interventions that put in place the teams, technology and processes to avoid medication errors. The project option we chose combines the components of both of these project options but focuses on medication management and compliance in the ambulatory setting within the patient's Baylor Clinic PCMH. Based on current estimates by our providers, we anticipate that more than 50% of patients in the Baylor Clinic have five or more medications. Ensuring that these medications are 1) appropriate, 2) taken correctly, 3) managed and 4) accessible will be important to improve clinical outcomes. By combining two of the project options 2.11.1 and 2.11.2 to create an "other" option encompasses both a process for avoiding medication errors and evidence based interventions to avoid medication errors. We intend to utilize a clinical pharmacist who will review patient mediations for those patients who have multiple prescriptions on a regular basis to ensure that medications are appropriate and to ensure the patient understands how and why they are taking the medications. Additionally, we plan to help patients obtain the medications they need through implementing a prescription assistance program to help patients who are eligible, qualify for mediations and provide medications to those patients who cannot afford prescriptions. We will attempt to provide medications at little to no cost for patients who are 150% below the federal poverty level, have one or more chronic diseases and remain compliant with their appointments and care regimens. Through this benefit and clinical pharmacist oversight and management, we expect adherence and compliance to medications will increase. The additional advantage to embedding this team within the PCMH is that patients will receive comprehensive care management to address all of their needs in one care venue. The Baylor Clinic on the Baylor University Medical Center at Dallas tends to see more patients and more complex patients than similar clinics at Baylor Medical Center at Irving and Garland. The patients at Baylor University Medical Center present with more issues and on average can be more difficult to manage. The difference in valuation for this project versus the other facilities comes from 1) managing more patients and 2) managing more difficult polypharmacy patients.

Goals and Relationship to Regional Goals

The goals for this project are: 1) to provide prescriptions at little to no cost for patients that qualify or help patients enroll in programs to receive their medications, 2) provide clinical pharmacist oversight to ensure that medications are appropriate and adhered to, 3) patients understand their medications and reasons for taking them 4) improve clinical outcomes related

to adhering to a medication regimen. The regional goals around managing chronic disease, ED utilization and behavioral health are all addressed through this project. Managing medications has ancillary effects on outcomes of multiple regional goals. If patients have access to and adhere to their prescriptions, chronic diseases and behavioral health issues would be under better control and there would be fewer exacerbations and visits to the ED. This program is also a mechanism to improve cost savings for the region through monitoring utilization, finding generic prescriptions where appropriate and avoiding costly complications and expensive ED/inpatient utilization.

Challenges

Challenges with the underserved population and medication management pose one of the most difficult hurdles to overcome in their care. First, the uninsured and Medicaid populations are highly transient and may not maintain the same PCMH for an extended period of time. This causes gaps in their medication regimen and can often lead to clinical exacerbations. Another challenge is access to medications and affordability. Patients who do not live near a pharmacy to fill their prescriptions or cannot afford to fill them will forgo this part of their care or ration the medications they have, leading to complications and escalations in their conditions. One trend we have seen in RHP 9 is indigent patients will go from ED to ED across the region to receive pain medications and because there is little coordination between hospital systems, there is no consistent record of the medications these patients receive. Lastly, patients that are polypharmacy often do not understand how to take their mediations appropriately or understand why they need the prescription at all. This lack of understanding also leads to non-compliance. With this project, we plan to address these challenges by providing medications at little to no cost for those patients that qualify, help patients that are eligible get on prescription assistance programs, provide prescriptions in the Baylor Clinic or nearby on the Baylor campus and offer clinical pharmacist oversight to monitor the patients' prescriptions and encourage compliance to a medication regimen.

5-year Expected Outcome for Provider and Patients

The 5-year expected outcomes for this project include: 1) a minimum of 480 patients with medication management in a PCMH setting, 2) increased frequency of medication reconciliation and management, 3) greater literacy around medication regimens and purposes, 4) efficient and effective utilization of medications for patients and 5) make the clinical pharmacist part of the PCMH care team. We through proactive management of mediations for the uninsured and Medicaid populations that clinical outcomes will improve, there will be fewer exacerbations of patient diseases.

Starting Point/Baseline

Baylor clinics have not historically provided any type of formal medication management or prescription assistance type program to patients. This is a new program that will be offered. We anticipate that on average 5% of Baylor Clinic patients will need medication management services. Based on historical data, almost 50% of patients have five or more prescriptions. We anticipate that on average about 5-10% of high risk Baylor Clinic patients will need focused and

frequent medication management services. We will have to establish the baseline in DY2 for the particular medications mentioned in the Category 3 outcomes and to determine the scope of high risk and polypharmacy patients.

Rationale

We selected this project for multiple reasons: 1) to offer a complete suite of services to patients in a Baylor Clinic PCMH ranging from chronic disease and behavioral management, basic primary care, specialty care and medications, 2) provide regular medication management and reconciliation to ensure appropriate utilization and adherence to prescriptions, 3) improve clinical outcomes by enforcing a medication regimen with patients and 4) improve adherence to medications by offering assistance in obtaining them. Successful programs that focus on coordinating care for patients include a medication management component.[298] Our overall goal is to create a PCMH for uninsured and Medicaid patients that is comprehensive and has co-located services to allow for greater convenience and compliance for patients. The total economic impact of medication non-adherence — which contributes to costly health complications, worsening of disease progression, and preventable utilization — has been estimated to be as much as $290 billion.[299] For patients with diabetes, those with low levels of adherence have almost twice the total annual healthcare costs of those with high levels of adherence ($16,498 versus $8,886).[300] The New England Healthcare Institute cited four components to improving medication management: 1) creating health care teams, 2) patient engagement and education, 3) payment reform and 4) leveraging health information technology.[301] This project addresses all of these components by 1) integrating the clinical pharmacist into the PCMH team, 2) educating the patient on why and how to take their medications, 3) offering prescription assistance and little to no cost medications for those who qualify and 4) using the Baylor Clinic electronic health record to monitor prescription regimens, fulfillments and utilization. There have been studies published stating that giving patients medications for free does not promote utilization and adherence.[302] In a study published in the New England Journal of Medicine, insured patients who were discharged from the hospital and had their prescriptions fully covered still only had adherence rates of 40-50%.[303] We will control for this in two ways: 1) we will not offer prescriptions for free unless the patient is 150% or below the FPL and/or has at least 1 chronic disease and 2) we will require a patient is seen regularly in the Baylor Clinic to receive medications.

Project Components

We have chosen applicable components from project options 2.11.1 and 2.11.2 to create our project around medication management.

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[298] Brown, RS. Six features of Medicare coordinated demonstration programs that cut hospital readmissions of high risk patients. *Health Aff*. 2012 June; 31(6):1156-1165.

[299] McKethan, A and Benner, J. Seizing the opportunity to improve medication adherence. *Health Aff.* 2012 August.

[300] New England Healthcare Institute. Thinking outside the pillbox: a systemwide approach to improving medication adherence for chronic disease. 2009 August.

[301] New England Healthcare Institute. Thinking outside the pillbox: a systemwide approach to improving medication adherence for chronic disease. 2009 August.

[302] McKethan, A and Benner, J. Seizing the opportunity to improve medication adherence. *Health Aff.* 2012 August.

[303] Choudhry, NK, Avorn, J, et. al. Full coverage for preventive medications after myocardial infarction. N Engl J Med 2011; 365:2088-2097

a. Develop criteria and identify targeted patient populations that are at high risk for developing complications, co-morbidities and/or utilizing emergency care services: *We will use our electronic health record to identify polypharmacy patients, patients who are on chronic disease medications and/or are high utilizers of the ED*

b. Develop tools to provide education and support to those patients at highest risk of an adverse drug event or medication error. *The clinical pharmacist we use for this program will help to educate the patient on these topics. We will ensure that materials are multilingual as well.*

c. Conduct root cause analysis of potential medication errors or adverse drug events and develop/implement processes to address those causes: *As one of our metrics, we will be designing the workflow for the clinical pharmacist and we will add this component into plan*

d. Implement pharmacist led chronic disease medication management services in collaboration with primary care and other healthcare providers: *The clinical pharmacist will be co-located in the Baylor Clinic and will interface with the PCMH team on a regular basis*

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. *This project will be part of an overall Baylor initiative that will be analyzing and evaluating the progress and challenges/barriers for all DSRIP projects. We will focus on identifying key challenges associated with the expansion and opportunities to scale the project where appropriate.*

Reasons for selecting outcome measures

The milestones and metrics we chose for this project are focused on increasing the number of patients who receive medication management services and by having outcomes that specifically focus on medications, this will encourage the care team to manage and monitor medications more frequently and with higher scrutiny. Although medication management is part of the patient's overall care in a Baylor Clinic, these milestones, metrics and outcomes will put a greater emphasis on ensuring that mediations are appropriate, regularly reconciled, adhered to and are utilized in order to improve clinical outcomes for patients. The outcome measure medications that we chose: ACE/ARB inhibitors, diuretics, anticonvulsants and antidepressants are drugs that are regularly used by our Baylor Clinic patients. Since many of

our patients have hypertension and CHF, adherence improvement to these drugs will help to facilitate better outcomes.

Unique community need identification number the project addresses: CN.11 Patient Safety and Quality and CN.4 Primary Care and Pediatrics

How the project significantly enhances an existing delivery system reform initiative
This project does not receive any federal funds and is a new initiative. It is focused on providing prescriptions for patients in need and ensuring that utilization of these prescriptions is appropriate and (cost and clinically) effective.

Related Category 3 Outcome Measures
The Category 3 outcomes for this project focus on medication management and monitoring for specific drugs that many of our Baylor Clinic use. These medications are also associated with complex chronic diseases and behavioral health issues. These drugs are an important part of a patient's care regimen to keep their conditions well controlled.

Outcome Measure #1: IT-1.2 Annual monitoring for patients on persistent medications angiotensin
converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non- standalone measure). Approximately 33% of Baylor Clinic patients are on an ACE/ARB medication regimen. Enforcing annual monitoring will improve quality and reconcile the patient's medication to ensure it is still appropriate. In a recent study in the New England Journal of Medicine, compliance to antihypertensives was 41%, beta blockers was 49% and statins were 55% after a patient suffered from an AMI.[304] We believe through consistent, proactive management and encouraging patient accountability for taking medications, these rates should increase.

Outcome Measure #2: IT-1.4 Annual monitoring for patients on persistent medications–diuretic (Non- standalone measure). Approximately 33% of Baylor Clinic patients are on a diuretic medication regimen. Enforcing annual monitoring will improve quality and reconcile the patient's medication to ensure it is still appropriate. A study that observed the correlation between a diuretic regimen and cardiovascular related hospitalizations found that patients who take the appropriate dose of diuretics at the appropriate time had a decrease risk of cardiovascular and heart failure related hospitalizations. A large component of the successful adherence was attributed to patient education and engagement in the medication regimen.[305]

[304] Choudhry, NK, Avorn, J, et. al. Full coverage for preventive medications after myocardial infarction. N Engl J Med 2011; 365:2088-2097

[305] Chui, M. A., Deer, M., Bennett, S. J., Tu, W., Oury, S., Brater, D. C. and Murray, M. D. (2003), Association Between Adherence to Diuretic Therapy and Health Care Utilization in Patients with Heart Failure. Pharmacotherapy, 23: 326–332. doi: 10.1592/phco.23.3.326.32112

Outcome Measure #3: IT-1.5 Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)**.** Only about 5% of Baylor Clinic patients are on an anticonvulsant medication regimen. This may be because there are no formal behavioral health programs in the Baylor Clinic, it is possible that identification of BH issues is low and utilization of anticonvulsants would increase with an increased emphasis on identifying BH issues. A study in Psychiatric Services found that 50% of patients that were given anticonvulsant prescriptions to treat bipolar disorder were non-adherent.[306] This issue can be resolved by explaining the risks v. benefits for taking an anticonvulsant.

Outcome Measure #4: IT-1.19 Antidepressant Medication Management - (Standalone measure) Approximately 20% of Baylor Clinic patients are on an antidepressant medication regimen. According to the Community Health Needs Assessment, behavioral health is a major issue in the region. The top 10 utilizers in the region had BH related issues.[307] While antidepressants are not the solution to this problem, managing depression can have other positive ancillary effects on clinical adherence and avoidance of BH exacerbations. This outcome enforces both short and long term adherence to this drug in order to avoid adverse events for patients. An article in the Journal of Clinical Psychiatry, evidence was found "…to support collaborative care interventions in a primary care setting demonstrated significant improvements in antidepressant drug adherence during the acute and continuous phase of treatment and were associated with clinical benefit, especially in patients suffering from major depression and were prescribed adequate dosages of antidepressant medication.[308]" Our project supports this methodology.

Relationship to other Projects

139485012.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
This medication management and prescription assistance program will be available to patients who are Baylor Clinic patients. The program will be incorporated into the overall care team and management of the patient.

Category 4 Population-focused improvements

RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.8, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7, RD-3, RD-4.1, RD-4.2

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Other related performing provider projects include:

Baylor Medical Center at Garland:	121790303.2.5
Baylor Medical Center at Irving:	121776204.2.5
UT Southwestern – Faculty Plan:	126686802.2.6

[306] Sajattovic, M, et. al. Treatment adherence with lithium and anticonvulsant medications among patients with bipolar disorder. *Psychiatric Services*. 58(6):855-63. 2007.
[307] RHP 9 Community Health Needs Assessment
[308] Vergouwen, AC, et. al. Improving adherence to antidepressants: a systematic review of interventions. *J Clin Psychiatry.* 64(12):1415-20. 2003.

Plan for Learning Collaborative. We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. The exchange of best practices and shared learning contributes significantly to CQI and will advance the success of this project.

Project Valuation

Baylor Health Care System spans over 2 RHPs. In order to be consistent in our valuation methodology, we have used the same process and technique across our hospitals to ensure consistency. Baylor Health Care System recognizes that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, we have priced our projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. That model computes separate values for impacts on the health care system, the individual and the community.

Baylor University Medical Center defined the population that will be directly impacted by the project as the underserved/uninsured patients that need prescription assistance and medication management services that are patients at a Baylor Clinic PCMH on the ***Baylor University Medical Center*** campus. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3. We believe this to be the correct number because, when a person is on the correct prescription and on an appropriate medication regimen, they are better able to manage their illnesses and have better clinical outcomes. To determine the value to the community of each, we concluded that, on a scale of 1 – 5, the value of this project is a *3.* We believe this to be the correct number because, when a person is positively impacted, unnecessary drug utilization decreases, patients are able to become well and resume being active and productive members in society.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million dollars. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

139485012.2.5	***2.11.3***	***2.11.3 (A-F)***	***OTHER PROJECT OPTION- EVIDENCE BASED INTERVENTIONS THAT PUT IN PLACE TEAMS, TECHNOLOGY AND PROCESSES TO ENSURE MEDICATION COMPLIANCE AND MANAGEMENT- MEDICATION MANAGEMENT AND PRESCRIPTION ASSISTANCE PROGRAM***
Baylor University Medical Center			*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.18* *139485012.3.19* *139485012.3.20* *139485012.3.21*	*3.IT-1.2* *3.IT-1.4* *3.IT-1.5* *3.IT-1.19*	*Annual monitoring for patients on persistent medications angiotensin converting enzyme (ACE) inhibitors/ angiotensin receptor blockers (ARBs) (Non-standalone measure)* *Annual monitoring for patients on persistent medications– diuretic (Non- standalone measure)* *Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)* *Antidepressant Medication Management - (Standalone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Implement/expand a medication management program/system Metric 1 [P-1.1]: Program elements Baseline/Goal: Determine program elements: people, processes and technologies Data Source: Documentation of program and written medication management plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $499,078 **Milestone 2** [P-2]: Develop criteria and identify patient populations Metric 1 [P-1.1]: Establish evidence based criteria for medication management planning in target population based on assessment of population needs Baseline/Goal: Conduct needs assessment to determine target	**Milestone 3** [P-1]: Implement/expand a medication management program/system Metric 1 [P-1.1]: Program elements Baseline/Goal: Create workflow and medication management plans for patients Data Source: Documentation of written medication management plan and provider workflow Milestone 3 Estimated Incentive Payment *(maximum amount):* $362,978 **Milestone 4** [P-4]: Implement an evidence based program based on best practices for medication reconciliation to improve medication management and continuity between acute care and ambulatory setting Metric 1 [P-4.1]: Written plan to provide medication reconciliation as	**Milestone 6** [I-9]: Manage medications for targeted patients Metric 1 [I-9.1]: Increase number of patients (meeting criteria for chronic condition) contacted or receiving medication management Goal: Provide medication management services to at least 320 patients over DY2 Data Source: E.H.R. Milestone 6 Estimated Incentive Payment *(maximum amount):* $1,092,101	**Milestone 7** [I-9]: Manage medications for targeted patients Metric 1 [I-9.1]: Increase number of patients (meeting criteria for chronic condition) contacted or receiving medication management Goal: Provide medication management services to at least 480 patients over DY2 Data Source: E.H.R. Milestone 7 Estimated Incentive Payment *(maximum amount):* $902,170

139485012.2.5	***2.11.3***	***2.11.3 (A-F)***	***OTHER PROJECT OPTION- EVIDENCE BASED INTERVENTIONS THAT PUT IN PLACE TEAMS, TECHNOLOGY AND PROCESSES TO ENSURE MEDICATION COMPLIANCE AND MANAGEMENT- MEDICATION MANAGEMENT AND PRESCRIPTION ASSISTANCE PROGRAM***
Baylor University Medical Center			*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.18* *139485012.3.19* *139485012.3.20* *139485012.3.21*	*3.IT-1.2* *3.IT-1.4* *3.IT-1.5* *3.IT-1.19*	*Annual monitoring for patients on persistent medications angiotensin converting enzyme (ACE) inhibitors/ angiotensin receptor blockers (ARBs) (Non-standalone measure)* *Annual monitoring for patients on persistent medications– diuretic (Non- standalone measure)* *Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)* *Antidepressant Medication Management - (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)**
population and medication needs Data Source: Written criterion for target population and program participation. Milestone 2 Estimated Incentive Payment *(maximum amount):* $499,078	part of transition from acute care to ambulatory care Baseline/Goal: Create plan for medication reconciliation Data Source: Documentation of program policies and procedures that ensure medication reconciliation upon admission and discharge at each care setting Milestone 4 Estimated Incentive Payment *(maximum amount):* $362,978 **Milestone 5** [I-9]: Manage medications for targeted patients Metric 1 [I-10.2]: Increase number of patients (meeting criteria for chronic condition) contacted or receiving medication management Goal: Provide medication management services to at least 100 patients over DY2 Data Source: E.H.R.		

139485012.2.5	***2.11.3***	***2.11.3 (A-F)***	***OTHER PROJECT OPTION- EVIDENCE BASED INTERVENTIONS THAT PUT IN PLACE TEAMS, TECHNOLOGY AND PROCESSES TO ENSURE MEDICATION COMPLIANCE AND MANAGEMENT- MEDICATION MANAGEMENT AND PRESCRIPTION ASSISTANCE PROGRAM***
Baylor University Medical Center			*139485012*
Related Category 3 Outcome Measure(s):	*139485012.3.18* *139485012.3.19* *139485012.3.20* *139485012.3.21*	*3.IT-1.2* *3.IT-1.4* *3.IT-1.5* *3.IT-1.19*	*Annual monitoring for patients on persistent medications angiotensin converting enzyme (ACE) inhibitors/ angiotensin receptor blockers (ARBs) (Non-standalone measure)* *Annual monitoring for patients on persistent medications– diuretic (Non- standalone measure)* *Annual monitoring for patients on persistent medications-anticonvulsant (Non-standalone)* *Antidepressant Medication Management - (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 5 Estimated Incentive Payment *(maximum amount):* $362,979		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 998,156	Year 3 Estimated Milestone Bundle Amount: $1,088,935	Year 4 Estimated Milestone Bundle Amount: $1,092,101	Year 5 Estimated Milestone Bundle Amount: $902,170
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $4,081,362			

Project Option: 2.1.1 – Enhance/Expand Medical Homes

RHP Project Identifier: 138910807.2.1
Performing Provider Name/TPI: Children's Medical Center/138910807

Provider: Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine. Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. There is one MyChildren's office in Grapevine (Region 10). Annually, Children's has approximately 600,000 patient contacts.

Provider's role in region's health care infrastructure (especially for Medicaid and indigent/uninsured): Children's has the largest market share for pediatrics in DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured).

MyChildren's payor mix is 75% Medicaid, 15% CHIP, 5% uninsured and 5% commercially insured.

Intervention: The purpose of this project is to transform the MyChildren's primary care offices into an NCQA-certified medical homes. It is a new initiative.

Need for the Project: The need for this project is documented in the community needs (CN) assessment, specifically: CN. 4: Primary Care and Pediatrics, CN. 8 Chronic Disease, CN. 9 Specialty Care.

Target Population: Children in RHP 9 covered by Medicaid and CHIP who use MyChildren's as their primary care provider. Provide primary care and preventive care services to children in the medical home setting to allow for better coordination care, improved health outcomes and improved satisfaction for children and their families.

Intervention	DY3	DY4	DY5	Total
Patients in NCQA certified medical home MyChildren's offices	18,000	19,400	19,800	20,700*
Patient contacts in NCQA certified medical home MyChildren's offices	58,000	62,000	62,500	182,500

* 10% attrition and new patients, 95% total due to payor mix

Category 1 & 2 Expected Patient Benefit: Process and improvement milestones were selected to support the successful implementation of the project.

Category 3 Outcome: OD-9 Preventive and Primary Care IT-9.2 ED appropriate utilization. (Stand-alone measure) Access to care delivered in a medical home environment should reduce both the use of the ED for inappropriate reasons as well as reduce overall use of the ED for patients receiving care in a medical home setting.

No additional federal grant dollars will be used for this project.

Project Description

- Develop, implement and spread across all Children's Medical Center (CMC) pediatric primary care centers, MyChildren's, a medical home team-based approach to care, transforming the existing fee-for-service delivery system from a reactive, fragmented approach to a proactive, comprehensive approach to improving the health of a population
- Expand staff roles to ensure that all staff are practicing at the top of their license; redesign processes in the CMC primary care centers to effectively use technology and staff to take responsibility for the health of a defined population and improve cost, quality, health and satisfaction outcomes
- Implement the effective use of IT systems, including patient identification, risk adjustment/analysis/scoring, predictive modeling, data warehousing, gaps in care alert system, provider profiling, outcomes measurement and reporting system capable of aggregating data at the individual patient level, chronic disease, pediatric physician panel, clinic and system-wide level
- Build, implement and spread a pediatric patient/family care coordination system across CMC primary care centers
- Build, implement and spread a health promotion and education program through the establishment of health resource centers

Goal and Relationship to Regional Goals

The goal of the project is to build infrastructure to expand the CMC primary care medical home capability and perform extensive innovation and redesign to achieve the outcome of NCQA Primary Care Medical Home recognition. This five-year project will involve capacity to manage chronic diseases, increase screening for potentially treatable and preventable conditions, and contribute to reduction in avoidable ED care and avoidable admissions/readmissions.

The expansion of a pediatric medical home approach complements and leverages the expansion of CMC's primary care centers such that the incremental primary care centers will be able to achieve a higher level of comprehensive, coordinated care and better quality, cost, health and satisfaction outcomes. By spreading the medical home model to all of our primary care centers to be able to empanel thousands of patients comprehensively and systematically, we can make a measureable difference in the experience, results and costs of health care.

Expanded prevention, wellness and patient/family education programs also feeds into the expansion of medical homes and more organized care delivery, better prevention and wellness programs specific to immunizations and well-child care, better prevention and management of chronic conditions, integrated physical-behavioral health care and better utilization of health care resources. Patients and families have better access to care, better access to behavior change programs, better access to social support networks and better access to health education. All of which is delivered in a patient/family-focused approach and in a culturally appropriate manner.

The medical home model increases opportunities to prevent disease and treat it early, where patients and families, upon patient discharge, can be scheduled for follow-up appointments at a medical home, thereby reducing the risk and consequences of worsening health conditions. Additionally, staff take responsibility for proactively reaching out to high risk patients, patients transitioning from one care setting to another and patients due to preventive services.

Challenges

A major challenge will be the thoughtful and careful redesign of care delivery and communications processes resulting in a team approach to patient/family centered care, requiring a formally structured, inclusive project management approach. This project will use proven process improvement methodologies to guide the redesign as well as use "lessons learned" from providers who have successfully redesigned care delivery in their practices.

Five-year Expected Outcome for Provider and Patients

Five-year expected outcomes include increased access to care, improved patient and family satisfaction, increased patient navigation and care coordination services for patients with chronic diseases, increased availability of information on healthy lifestyle choices and self-management through new community resource centers and decreased low complexity Emergency Department visits. The project is related to the regional goals of increased access to medical homes and improved patient and family satisfaction with services.

Starting Point/Baseline

Baseline measurements will be established using DY1 data.

Rationale

According to Regional Health Partnership IX Community Needs Assessment Report, Dallas Fort Worth Hospital Council, April 2012, the demand for both primary and specialty care services exceeds that of available physicians in these areas, thus limiting health care access for many low level management or specialized treatment for prevalent health conditions. Additionally, many individuals in North Texas suffer from chronic diseases that present earlier in life, are becoming more prevalent, and exhibit more severe complications. Finally, emergency departments are treating high volumes of patients with preventable conditions, or conditions

that are suitable to be addressed in a primary care setting. Additionally, re-admissions are higher than desired, particularly for those with severe chronic diseases or behavioral health.

Additionally, according to Regional Health Partnership IX Community Needs Assessment Report, Dallas Fort Worth Hospital Council, April 2012, the impact of the limited primary and specialty care is significantly profound for children and families in the region. With the current pediatric need being more than 80% of the current supply, in rural and urban areas the demand for primary care services is much higher than the current supply. In Dallas County alone, over 36.2% of children were enrolled in Medicaid in 2010, exacerbating the issue of availability of primary care access and treatment. Additionally, data indicates that many of the pediatric specialists are limited, creating a backlogged pipeline for those needing specialty services after seeking primary care.

As we seek to develop pediatric medical homes through National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) recognition, MyChildren's will have the opportunity to provide better care through improved prevention screenings and routine primary and chronic care. The majority of the MyChildren's primary care providers are still functioning in a more traditional fee for service approach. We want to make sure the pediatric medical home model is embedded within the care delivery model at MyChildren's so that all patients can receive the right care in the right place at the right time. This is a strategic priority for MyChildren's because by providing more patients with family-centered, culturally appropriate coordinated care services grounded in their primary care medical homes, children can stay healthier and families can take better care of their children, thereby reducing avoidable ED visits, specialty visits, admissions and readmissions. Children will be identified via the IT support systems and then receive this care in a proactive, planned manner so that they can receive evidence-based interventions across the care continuum. The staff will be complemented to include nutritionists, social workers, community health workers and therapists as part of the family-focused patient care teams. Services will include group visits, care management, chronic care management, telephone outreach and home health care. Heavy emphasis will be placed on a patient/family-focused approach that incorporates evidence-based clinical protocols, and is applied in a consistent and documented manner. Rigorous measurement of both processes of care and pediatric outcomes will ensure continuous improvement and sustainability over time.

MyChildren's will utilize the IT support systems to track and monitor prevention and wellness programs, with targeted improvements in key quality indicators, such as well-child visits, immunizations and potentially preventable acute care services. Currently, primary care capacity, resources, infrastructure and technology are severely limited. Our goal is to better treat the volume of patients who need preventive and wellness interventions in addition to chronic care management. The IT support systems will promote tracking, trending timely intervention and support patient/family education through community-based resource centers.

The community resource centers will enable patients and families the opportunity to learn together, learn from each other, and achieve behavior change, which is sustainable to both prevent and better manage chronic illnesses. The community resource center's programs will be delivered by community leaders in a culturally appropriate manner. Referrals of identified patients and families will be made to community resource centers, where classes, group visits, training sessions, behavior modification programs, social networking and family counseling services will be provided to supplement the services provided in the primary care office.

Intervention	DY3	DY4	DY5	Total
Patients in NCQA certified medical home MyChildren's offices	18,000	19,400	19,800	20,700*
Patient contacts in NCQA certified medical home MyChildren's offices	58,000	62,000	62,500	182,500

* 10% attrition and new patients, 95% total due to payor mix

Project Components

All of the project components of 2.1 will be included in this project:

a. Utilize a gap analysis to assess and/or measure the primary care providers' readiness for National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) status
b. Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status
c. Conduct educational sessions for primary care physician offices, hospital board of directors, medical staff and senior leadership on PCMH elements, rationale and vision
d. Conduct quality improvement for the project using methods such as rapid cycle improvement

All milestones and metrics are based on the relevancy to RPH IX's population, community needs, RHP priorities and the starting point for the project.

Unique community need (CN) identification number the project addresses:

- CN. 4: Primary Care and Pediatrics
- CN. 8 Chronic Disease
- CN. 9 Specialty Care

How the project significantly enhances and existing delivery system reform initiative

This project represents a new initiative for Children's and its system of primary care providers: MyChildren's. Significant changes to practice, staffing, process and productivity will be reflected in the process of becoming qualified medical homes.

Related Category 3 Outcome Measures

OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization. (Stand-alone measure). This outcome measure was selected to track the reduction in inappropriate use of the Emergency Department by patients and families who receive their primary care in a medical home environment. The medical home environment is designed to provide a holistic approach to care which should include education and resources to select the correct level of care needed. Access to care delivered in a medical home environment should reduce both the use of the ED for inappropriate reasons as well as reduce overall use of the ED for patients receiving care in a medical home setting.

Relationship to other projects

Other related Children's Medical Center projects include:

138910807.1.1	Expand Primary Care Capacity
138910807.1.2	Expand Primary Care Hours
138910807.1.3	Implement Disease Management
138910807.1.4	Expand Pediatric Behavioral Health
138910807.2.2	Implement/Enhance Evidence-based Health Promotion Programs
138910807.2.3	Expand/Enhance Patient/Family Navigation
138910807.2.4	Implement/Expand Care Transitions Program

This project is related to the other Catgegory 1 and 2 projects proposed by children's because four of the other projects (Expand Primary care clinics and hours, Implement Disease Management and Expand Pediatric Behavioral Health) are all focused within the MyChildren's practices. The remaining three projects support overall population health and are supportive of this project to transform MyChildren's locations into NCQA certified medical homes.

Related Category 4 Population-focused Improvements

RD-1 Potentially Preventable Admissions
RD-2 30-day readmissions
RD-3 Potentially Preventable Complications
RD-6 Initial Core Set of Health Care Quality Indicators

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Related performing provider projects include:

Doctors Hospital at White Rock (Tenet):	094194002.2.1
Medical City Dallas Hospital:	020943901.2.4
Methodist Dallas Hospital:	135032405.2.3
Parkland Health & Hospital System:	127295703.2.1
Parkland Health & Hospital System:	127295703.2.11
Texas Health Presbyterian Hospital Dallas:	020908201.2.3

Plan for Learning Collaborative. We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. The exchange of best practices and shared learning contributes significantly to CQI and will advance the success of this project.

Project Valuation

This project was valued using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	9	1.80
Population Served / Project Size	25%	8	2.00
Alignment with Community Needs	20%	9	1.80
Cost Avoidance	15%	8	1.20
Sustainability	15%	9	1.35
Partnership Collaboration	5%	7	0.35
	100%		8.50

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact

Moderate Weakness: Lessens impact

Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into

adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

The project will not use additional federal grant dollars.

References

1. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html

2. Nashmia Qamar, Andrea A Pappalardo, Vineet M Arora, and Valerie G Press . Patient-centered care and its effect on outcomes in the treatment of asthma. *Patient Relat Outcome Meas*. 2011 July; 2: 81–109.

3. Reid A, Baxley E, Stanek M, Newton W. Practice transformation in teaching settings: lessons from the I³ PCMH collaborative. *Fam Med*. 2011 Jul-Aug;43(7):487-94.

4. Mangione-Smith R, Schiff J, Dougherty D. Identifying children's health care quality measures for Medicaid and CHIP: an evidence-informed, publicly transparent expert process. *Acad Pediatr*. 2011 May-Jun;11(3 Suppl):S11-21.

138910807.2.1	***2.1.1***	***2.1.1 (A-D)***	***ENHANCE/EXPAND MEDICAL HOMES***	
Children's Medical Center				138910807
Related Category 3 Outcome Measure(s):	*138910807.3.5*	*3.IT-9.2*	*ED appropriate utilization (Stand-alone measure)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-2): Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. 63 P-2.1. Metric: Performing Provider policies on medical home a. Data Source: Performing Provider's "Policies and Procedures" documents b. Rationale/Evidence: Operationalizing the work as part of the "Policies and Procedures" for an organization will make the work the "norm" or expectation for the organization and its employees. c. Goal: Policies and systems in place by 9/30/13 Milestone 1 P-2.1 Estimated Incentive Payment *(maximum amount):* $ $ 1,947,530 Milestone 2 (P-4): Develop staffing plan to expand primary care team roles; Expand and redefine the roles and responsibilities of primary care team members.66 P-4.1. Metric: Expanded primary care		Milestone 3 (P-1): Implement the medical home model in primary care clinics P-1.1. Metric: Increase number of primary care clinics using medical home model a. Numerator: Number of primary care clinics using medical home model b. Denominator: Total number of eligible primary care clinics c. Rationale/Evidence: NAPH found that nearly 40% of programs could offer either anecdotal or quantitative evidence of reduced ED usage—attributed to the redirection of primary care-seeking patients from the ED to a medical home.62 In addition to reductions in ED utilization, the medical home model has helped improve the delivery and quality of primary care and reduce costs. d. Goal: 100% of eligible clinics (3 clinics) implemented with medical home model by 9/30/14 Milestone 3: P-1.1 Estimated Incentive Payment *(maximum amount)* $ 1,991,860	Milestone 5 (I-18): Obtain medical home recognition by a nationally recognized agency 82(e.g., NCQA, RAC, AAHC, etc.). The level of medical home recognition will depend on the practice baseline and accrediting agency. I-18.1. Metric: Medical home recognition/accreditation a. Numerator: number of sites or clinics receiving recognition/accreditation b. Denominator: total number of sites or clinics eligible for recognition/accreditation. c. Data Source: Documentation of recognition/accreditation from nationally recognized agency (e.g., NCQA) d. Rationale/Evidence: It is important to validate the medical home service being provided by seeking and receiving recognition/accreditation. Some safety net sites that have attained NCQA accreditation "reported that they have become far more sophisticated as a result of the application effort and have invested in quality improvement efforts that might otherwise have gone	Milestone 8 (I-12): Based on criteria, improve the number of eligible patients that are assigned to the medical homes. I-12.1. Metric: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the Performing Provider a. Numerator: Number of eligible patients assigned to a medical home b. Denominator: Total number of eligible patients c. Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider d. Rationale/Evidence: Murray M, Davies M, Boushon B, Panel Size: How Many Patients Can One Doctor Manage? *Fam Pract Manag.* 2007 Apr;14(4):44-51 e. Goal: 75% of eligible patients : 14,850 , patients assigned to a medical home by 9/30/16 Milestone 8 I-12.1 Estimated Incentive Payment *(maximum amount):* $1,605,841 Milestone 9 (I-13): New patients assigned to medical homes receive their first appointment in a timely

138910807.2.1	*2.1.1*	*2.1.1 (A-D)*	*ENHANCE/EXPAND MEDICAL HOMES*	
	Children's Medical Center			138910807
Related Category 3 Outcome Measure(s):	*138910807.3.5*	*3.IT-9.2*	*ED appropriate utilization (Stand-alone 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)**
team member roles; a. Data Source: Revised job descriptions b. Rationale/Evidence: "Primary care physicians are expected to provide acute, chronic, and preventive care to their patients while building meaningful relationships with those patients, and managing multiple diagnoses according to a host of evidence-based guidelines. A research study estimates that it would take 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 patients plus an additional 10.6 hours to adequately manage this panel's chronic conditions.67 It is clear that primary care physicians in the 15-minute visit can no longer do what their patients expect and deserve." c. Goal: Staffing plan in place by 9/30/13 Milestone 2: P-4.1 Estimated Incentive Payment *(maximum amount):* $ 1,947,531	Milestone 4 (P-7): Track the assignment of patients to the designated care team P-7.1. Metric: Tracking medical home patients a. Data Source: Submission of tracking report. Can be tracked through the practice management system, EHR, or other documentation as designated by Performing Provider b. Rationale/Evidence: Review panel status (open/closed) and panel fill rates on a monthly basis for equity to be able to adjust to changing environment (e.g., patient preference, extended provider leave). c. Goal: Tracking report developed by 9/30/14 Milestone 4 P-7 Estimated Incentive Payment *(maximum amount):* $ 1,991,861		unrealized". e. Goal: 100% of eligible clinics (3 clinics) receive medical home certification by 9/30/15 Milestone 5: I-18 Estimated Incentive Payment *(maximum amount):$* $ 1,325,848 Milestone 6 (I-12): Based on criteria, improve the number of eligible patients that are assigned to the medical homes. I-12.1. Metric: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the Performing Provider a. Numerator: Number of eligible patients assigned to a medical home b. Denominator: Total number of eligible patients c. Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider d. Rationale/Evidence: Murray M, Davies M, Boushon B, Panel Size: How Many Patients Can One Doctor Manage? *Fam Pract Manag.* 2007 Apr;14(4):44-51	manner I-13.1. Metric: Improve number or percent of new patients assigned to medical homes contacted for first patient visit within 60-120 days a. Numerator: # new patients contacted within specified days b. Denominator: Total number of new patients c. Data Source: Practice management or scheduling systems, registry, EHR, or other documentation as designated by Performing Provider d. Rationale/Evidence: It is important to get new patients into the medical home in a timely manner. e. Goal: 75% of patients, 990 patients, receive first appointment within or before 60 to 120 days of request by 9/30/16 Milestone 9: I-13 Estimated Incentive Payment *(maximum amount):* $*1,605,841*

138910807.2.1	*2.1.1*	*2.1.1 (A-D)*	*ENHANCE/EXPAND MEDICAL HOMES*	
Children's Medical Center				138910807
Related Category 3 Outcome Measure(s):	*138910807.3.5*	*3.IT-9.2*	*ED appropriate utilization (Stand-alone 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)**
			e. Goal: 50% of eligible patients , 9,700 patients assigned to a medical home by 9/30/15 Milestone 6 I-12.1 Estimated Incentive Payment *(maximum amount):* $ 1,325,848 Milestone 7 (I-13): New patients assigned to medical homes receive their first appointment in a timely manner I-13.1. Metric: Improve number or percent of new patients assigned to medical homes contacted for first patient visit within 60-120 days a. Numerator: # new patients contacted within specified days b. Denominator: Total number of new patients c. Data Source: Practice management or scheduling systems, registry, EHR, or other documentation as designated by Performing Provider d. Rationale/Evidence: It is important to get new patients into the medical home in a timely manner. e. Goal: 50% of patients, 485 patients, receive first appointment within or before 60 to 120 days of	

138910807.2.1	*2.1.1*	*2.1.1 (A-D)*	*ENHANCE/EXPAND MEDICAL HOMES*	
Children's Medical Center				138910807
Related Category 3 Outcome Measure(s):	*138910807.3.5*	*3.IT-9.2*	*ED appropriate utilization (Stand-alone 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)**
			request by 9/30/15 Milestone 7: I-13 Estimated Incentive Payment *(maximum amount):* $ 1,325,849	
Year 2 Estimated Milestone Bundle Amount: $ 3,895,061		Year 3 Estimated Milestone Bundle Amount: $3,983,721	Year 4 Estimated Milestone Bundle Amount: $ 3,977,545	Year 5 Estimated Milestone Bundle Amount: $ 3,211,682
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 15,068,009				

Project Option: 2.6.1 - Implement Evidence-based Health Promotion Programs

RHP Project Identifier: 138910807.2.2
Performing Provider Name/TPI: Children's Medical Center/138910807

Provider: Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine. Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. Annually, Children's has approximately 600,000 patient contacts.

Provider's role in region's health care infrastructure: Children's has the largest market share for pediatrics in DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured). Children's is considered the safety net hospital for pediatrics in region.

Intervention: The purpose of this project is to work with agencies and organizations in Dallas County through a formal steering committee to align and coordinate community-based prevention and wellness activities in the focused areas of asthma and diabetes to improve the health and self-management of children and their families. This is a new initiative for Children's.

Need for the Project: The need for this project is documented in the community needs (CN) assessment, specifically: CN. 1: Community Overview and Description, CN. 2: Regional Healthcare Infrastructure and Patient Migration Patterns, CN. 4: Primary Care and Pediatrics, CN 8: Chronic Disease, CN. 9: Specialty Care and CN. 12 Emergency Department Usage and Readmissions.

Target Population: The entire population of children, approximately 650,000 children, in Dallas County can be impacted by this initiative. The goal of the project is to organize, align and integrate the fragmented individual not-for-profit community health improvement activities into an organized and complimentary set of data-based and sustainable interventions focused on specific areas of need, such as asthma and diabetes. The outcomes are also patient and family-centered in that patients and families help identify the challenges of living with chronic illnesses and participate in designing interventions that are more relevant to the culture and lifestyles of the community and are therefore, more likely to be adopted and become self-sustaining. Initially the program will focus on children in Dallas County with asthma, approximately 65,000 children in DY2.

	DY3	DY4	DY5
Pediatric population Dallas County	650,000	657,000	670,000
Children with Asthma	65,000	65,700	67,000
70% Children with Asthma Medicaid, CHIP and	45,500	46,000	47,000

uninsured			

Category 1 & 2 Expected Patient Benefit: Process and improvement milestones were selected to support the successful implementation of the project.

Category 3 Outcome: OD-9 Preventive and Primary Care. ~~IT 9.2 ED appropriate utilization~~ IT-9.3 Pediatric and Young Adult Asthma Emergency Department Visits (Stand-alone measure). This measure was selected because the project is designed to support appropriate utilization of ED services and improve the health of low-income children by coordinating and organizing community-based health improvement and disease prevention activities targeted for children and their families and implement evidence-based interventions through these activities to support overall health improvement in general and reduction of ED visits specifically.

The project will not use additional federal grant dollars.

Project Description

We propose to improve the quality of life for children with chronic illness, prevent illness and compress parents' time from work and absenteeism by advancing a collective impact health model to effectively engage children, their families and communities in self-management and lifestyle behaviors that enhance health. This initiative is called the Health and Wellness Alliance for Children. We will work with community agencies and organizations through a formal steering committee and individual work groups to align and coordinate community-based prevention and wellness activities in the focused areas of asthma and diabetes to improve health and self-management skills of children and their families. We will use a variety of strategies to improve the health of children in Dallas County including programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in children, youth and their families. We will establish self-management programs and wellness programs using evidence-based designs. We will engage community health workers, both promotores and Grand Aides, in an evidence-based program to increase health literacy in children, youth and their families.

The collective impact process is designed to organize, align and integrate the fragmented individual not-for-profit community health improvement activities into an organized and complimentary set of data-based and sustainable interventions focused on specific areas of focus, such as asthma and diabetes. The outcomes of a collective impact process is also patient and family-centered in that patients and families help identify the challenges of living with chronic illnesses and participate in designing interventions that are more relevant to the culture and lifestyles of the community and are therefore, more likely to be adopted and become self-sustaining.

The Health and Wellness Alliance will organize a community-based stakeholder steering committee, including patient families, health care organizations, the health department, United

Way, Dallas Independent School District, business leaders, non-prfoits and elected officials. The steering committee will appoint work groups whose responsibility is to rigorously design, implement and measure outcomes of focused community-based interventions to improve the health of populations with chronic illness through behavior change and self-management strategies. To achieve sustainability, the Health and Wellness Alliance will build a small infrastructure to coordinate and measure the impact of the interventions as well as generate ongoing financial support through philanthropy and grant submissions.

A major initiative of the Health and Wellness Alliance will be to organize and establish a "virtual safety net" of primary care for the underserved, thus linking all the health care providers through information exchange, evidence-based treatment protocols and collective solutions to challenges such as access to after-hours care and access to specialty services.

Goals and Relationship to Regional Goals

The goals of the project are to increase healthy lifestyle behaviors, engage the community in developing self-management skills, to improve health literacy, reduce unnecessary ED utilization, reduce potentially preventable admissions, reduce 30-day readmissions and reduce potentially preventable complications. This project is related to the regional goals of improving access to primary and preventive care, decreasing potentially avoidable admissions, decreasing potentially avoidable readmissions, decreasing potentially avoidable complications, increasing self-management skills, increasing adherence to self-care plans and increasing the availability of primary and preventive services.

Challenges

The challenges of this project will include gaining community engagement, coordinating large-scale interventions and maintaining sensitivity to cultural norms. The challenges will be addressed through the organization of this project, engagement of community leaders, reliance on evidence-based methodologies, and using quality improvement strategies to assess and intervene during the project. Project challenges will also be addressed using CQI techniques described in this narrative.

5-year Expected Outcome for Provider and Patients

Appropriate utilization of ED services and improve the health of low-income children.

Starting point/baseline
Baseline numbers will be established during DY2.

Rationale

According to Regional Health Partnership IX Community Needs Assessment Report, Dallas Fort Worth Hospital Council, April 2012, the demand for both primary and specialty care services exceeds that of available medical physicians in those areas; thus limiting health care access for many low level management or specialized treatment for prevalent health conditions. Additionally, many individuals in North Texas suffer from chronic diseases that present earlier in life, are becoming more prevalent, and exhibit more severe complications. Finally, emergency departments are treating high volumes of patients with preventable conditions, or conditions that are suitable to be addressed in a primary care setting. Additionally, re-admissions are higher than desired, particularly for those with severe chronic diseases or behavioral health conditions.

According to Regional Health Partnership IX Community Needs Assessment Report, Dallas Fort Worth Hospital Council, April 2012, the impact of the limited primary and specialty care is significantly profound for children and families in the region. With the current pediatric need being more than 80% of the current supply, in rural and urban areas the demand for primary care services is much higher than the current supply. In Dallas County alone, over 36.2% of children were enrolled in Medicaid in 2010, exacerbating the issue of availability of primary care access and treatment. Additionally, data indicates that many of the pediatric specialists are limited, creating a backlogged pipeline for those needing specialty services after seeking primary care.

Children's Medical Center is the safety net hospital for children in Dallas County, providing the majority of emergency department, specialty and inpatient care to Medicaid and safety net patients/families. Providing community support to address the causes and exacerbation of asthma and diabetes will have a positive impact on the health of the children of Dallas County and reduce the overall cost of care and it will strengthen community engagement in healthy lifestyle behaviors. Initially the program will focus on children in Dallas County with asthma, approximately 65,000 children.

Project Components

- Conduct quality improvement for the project

This project will employ the Collective Impact model to support Continuous Quality Improvement (CQI). This model is based on research reported in the Stanford Social Innovation Review (Kania J and Kramer M, Winter 2011). The research identified five conditions common in successful large-scale efforts for social change: common agenda, shared management systems, mutually reinforcing activities, continuous communication and a backbone support organization. The backbone support organization, The Health and Wellness Alliance for Children, will be developed with the tools and infrastructure based on backbone organizations of large-scale, successful social change projects. The staff in the Alliance will plan, manage and

support the initiatives of the projects. The staff will provide the tools and support for Continuous Quality Improvement among the members of the Alliance. Tools will include but not be limited to proven improvement tools such rapid cycle improvement, LEAN and Six Sigma concepts.

Unique community need (CN) identification number the project addresses:

CN.1: Community Overview and Description
CN.2: Regional Healthcare Infrastructure and Patient Migration Patterns
CN.4: Primary Care and Pediatrics, CN 8: Chronic Disease
CN.9: Specialty Care
CN.12 Emergency Department Usage and Readmissions

How the Project significantly enhances an existing delivery system reform initiative

This project represents a new initiative for Children's Medical Center. This project is data driven and addresses areas of poor performance (overuse of ED services and inpatient services) and a disparity group ('safety net' children).

The milestones and metrics for this project are based on the relevancy to the RHP IX's population, the community needs, RHP priority (this project was rated the second highest priority level by the participating providers in the RHP), and the current state (starting point).

Related Category 3 Outcome Measures

OD-9 Preventive and Primary Care. IT-9.3 Pediatric and Young Adult Asthma Emergency Department Visits (Stand-alone measure)
This measure was selected because the project is designed to support appropriate utilization of ED services and improve the health of low-income children with asthma by coordinating and organizing community-based health improvement and disease prevention activities targeted for children and their families and implement evidence-based interventions through these activities to support overall health improvement in general and management of asthma specifically.

Relationship to Other Projects

Other Children's Medical Center projects include:

138910807.1.1 Expand pediatric primary care capacity
130910807.1.2 Expand pediatric primary care capacity
138910807.1.3 Implement and utilize pediatric-specific disease management system
138910807.1.4 Expand pediatric behavioral health capacity

138910807.2.1 Enhance/Expand pediatric medical homes
1389108072.3 Implement/expand patient navigation program
138910807.2.4 Implement/expand care transitions program

This project supports the work of the other projects which focus around care delivery on an individual basis by providing a framework for supporting community-based programs which focus on health promotion on a population and community focused basis.

Related Category 4 Population-focused improvements

RD-1 Potentially Preventable Admissions
RD-2 30-day readmissions
RD-3 Potentially Preventable Complications
RD-6 Initial Core Set of Health Care Quality Indicators

These indicators of population-focused improvement should improve as coordinated efforts to improve health on a population basis are implemented.

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

There are no related health promotion projects in RHP 9

Project Valuation

This project was valued using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	9	1.80
Population Served / Project Size	25%	9	2.25
Alignment with Community Needs	20%	9	1.80
Cost Avoidance	15%	7	1.05
Sustainability	15%	7	1.05
Partnership Collaboration	5%	9	0.45
	100%		8.40

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness

	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact

Moderate Weakness: Lessens impact

Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

The project will not use additional federal grant dollars.

References

1 Blaakman Implementation of a community-based secondhand smoke reduction intervention for caregivers of urban children with asthma: process evaluation, successes and challenges**.** Health Educ Res. 2012 Jun 20.

2 Celano MP, Holsey CN, Kobrynski LJ Home-based family intervention for low-income children with asthma: a randomized controlled pilot study. J Fam Psychol. 2012 Apr;26(2):171-8. Epub 2012 Feb 20.

3 Nichols P, Ussery-Hall A, , Griffin-Blake S, Easton A. The Evolution of the Steps Program, 2003-2010: Transforming the Federal Public Health Practice of Chronic Disease Prevention Prev Chronic Dis. 2012 Feb;9:E50. Epub 2012 Feb 2.

4 Norman CD, Yip AL. eHealth Promotion and Social Innovation with Youth: Using Social and Visual Media to Engage Diverse Communities. Stud Health Technol Inform. 2012;172:54-70.

5 Garson A, Green D, Rodriguez L, Beech R, Nye C. A New Corps of Trained Grand-Aides Has Potential to Extend Reach of Primary Care Workforce and Save Money. Health Affiars. 2012, 31; 1016-1021.

138910807.2.2	***2.6.1***	***PROJECT COMPONENTS: NA***	***IMPLEMENT EVIDENCE-BASED HEALTH PROMOTIONS PROGRAM***	
Children's Medical Center				138910807
Related Category 3 Outcome Measure(s):	*138910807.3.6*	*IT-9.3*	*Pediatric and Young Adult Asthma Emergency Department Visits (Stand-alone measure)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): Conduct an assessment of health promotion programs that involve community health workers at local and regional level. P-1.1. Metric: Document regional assessment a. Data Source: Performing Provider assessment and summary of findings b. Rationale/Evidence: The importance of this milestone is to identify, support and compliment already existing resources in the community for health promotion programs. c. Goal: Assessment completed 9/30/13 Milestone 1: P-1.1 Estimated Incentive Payment *(maximum amount):* $ 1,687,860 Milestone 2 (P-5): Execution of evaluation process for project innovation. P-5.1. Metric: Document evaluative process, tools and analytics. a. Data Source: Performing Provider contract or other documentation of implementation TBD by Performing	Milestone 3 (P-2): Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community P-2.1. Metric: Document innovational strategy and plan. a. Data Source: Performing Provider evidence of innovational plan b. Rationale/Evidence: Documentation of innovational strategy and plan. c. Goal: Two (2) evidence-based processes developed by 9/30/14 Milestone 3: P.2 Estimated Incentive Payment *(maximum amount):* $ 1,150,853 Milestone 4 (P-3): Implement, document and test an evidence-based innovative project for targeted population P-3.1. Metric: Document implementation strategy and testing outcomes. a. Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider. b. Rationale/Evidence: Documentation of implementation strategy and testing		Milestone 6 (I-6): Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. I-6.1. Metric: TBD by Performing Provider based on measure described above a. Numerator: Total number of patients in defined population who received innovative intervention. b. Denominator: Total number of patients in defined population. c. Data Source: Patient records d. Rationale/Evidence: To test innovative intervention model variables (better health, improved care and lower costs). e. Goal: 10% (4,600) of the identified population of 46,000 children by 9/30/2015 Milestone 6: I-6: Estimated Incentive Payment *(maximum amount):* $ 3,447,205	Milestone 7 (I-8): Increase access to health promotion programs and activities using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to evidence-based health promotion programs but are not required. I-8.1. Metric: Increase percentage of target population reached. a. Numerator: Number of individuals of target population reached by the innovative project. b. Denominator: Number of individuals in the target population. c. Data Source: Documentation of target population reached, as designated in the project plan. d. Rationale/Evidence: This metric speaks to the efficacy of the innovative project in reaching it targeted population. e. Goal: 20% (9,400) of the identified population of 47,000 children by 9/30/2016 Milestone 7: I.8: Estimated Incentive Payment *(maximum amount):*

138910807.2.2	*2.6.1*	***PROJECT COMPONENTS:*** ***NA***	***IMPLEMENT EVIDENCE-BASED HEALTH PROMOTIONS PROGRAM***	
Children's Medical Center				138910807
Related Category 3 Outcome Measure(s):	*138910807.3.6*	*IT-9.3*	*Pediatric and Young Adult Asthma Emergency Department Visits (Stand-alone 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)**
Provider b. Goal: Evaluation process executed by 9/30/13 Milestone 2: P.5: Estimated Incentive Payment *(maximum amount):* $ 1,687,860	outcomes. c. Goal: One (1) project implemented, documented and tested by 9/30/14 Milestone 4 P.3: Estimated Incentive Payment *(maximum amount):* $ 1,150,853 Milestone 5 (P-4): Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. P-4.1. Metric: Document learning and diffusion strategic plan a. Date Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider. b. Rationale/Evidence: Documentation of learning and diffusion strategic plan and actions. c. Goal: Execution of one (1) learning and diffusion strategy by 9/30/14 Milestone 5: P.4: Estimated Incentive Payment *(maximum amount):* $ 1,150,852		$ 2,783,458
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 3,375,720	Year 3 Estimated Milestone Bundle Amount: $ 3,452,558	Year 4 Estimated Milestone Bundle Amount: $ 3,447,205	Year 5 Estimated Milestone Bundle Amount: $ 2,783,458

138910807.2.2	***2.6.1***	***PROJECT COMPONENTS:*** ***NA***	***IMPLEMENT EVIDENCE-BASED HEALTH PROMOTIONS PROGRAM***	
Children's Medical Center				138910807
Related Category 3 Outcome Measure(s):	*138910807.3.6*	*IT-9.3*	*Pediatric and Young Adult Asthma Emergency Department Visits (Stand-alone 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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 13,058,941				

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program

RHP Project Identifier: 138910807.2.3
Performing Provider Name/TPI: Children's Medical Center/138910807

Provider: Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine. Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. Annually, Children's has approximately 600,000 patient contacts.

Provider's role in region's health care infrastructure: Children's has the largest market share for pediatrics in DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured). Children's is considered the safety net hospital for pediatrics in region.

Intervention: We propose to develop and utilize a high-intensity, culturally appropriate care management system for Medicaid and safety net children and families, most of whom utilize Children's Medical Center's ED, specialty clinics and inpatient hospital as a safety net provider for children.

Need for the Project: The need for this project is documented in the community needs (CN) assessment, specifically: CN. 3 Healthcare capacity, CN. 4: Primary Care and Pediatrics, CN 8: Chronic Disease, CN. 9: Specialty Care and CN. 12 Emergency Department Usage and Readmissions.

Target Population: The target population is children who inappropriately use the emergency department or other high-intensity services, approximately 44,000 unique patients. Children's Medical Center is the safety net hospital for children in Dallas County, providing the majority of ED, specialty and inpatient care to Medicaid and safety net patients/families. Identification of at-risk patients/families, development/implementation of care management plans across the continuum of care, effective and culturally appropriate patient/family education, communication with the patient's primary care physician, and tracking/follow-up of patients across the care continuum will ensure a closed-loop program for Medicaid and safety net children and families.

	DY3	DY4	DY5
Unique patients requiring navigation	42,600	43,000	44,000
Approximately 90% Medicaid, CHIP or uninsured	38,500	39,000	40,000

Category 1 & 2 Expected Patient Benefit: Process and improvement milestones were selected to support the successful implementation of the project.

Category 3 Outcome: OD-9 Preventive and Primary Care. IT-9.2 ED appropriate utilization (Stand-alone measure). This measure was selected because the project is designed to support appropriate utilization of ED services and improve the health of low-income children.
This project is not supported by other Federal grants.

Project Description

We propose to develop and utilize a high-intensity, culturally appropriate care management system for Medicaid and safety net children and families, most of whom utilize Children's Medical Center's ED, specialty clinics and inpatient hospital as a safety net provider for children:

- Creation of an IT-support system to identify, register, risk-adjust and track children across a continuum of care. Children will be registered in the system by virtue of a trigger event at CMC, and assessed from a medical and social risk perspective
- Creation of culturally appropriate materials and processes for educating patients and their families
- Creation of intensive case management plans for the high risk situations involving patient navigators, case managers, specialty physicians, primary care physicians, home care, managed care plan, pharmacist and social worker; communication of plan to all involved providers, with team conferences, as necessary, organized by case management program
- Utilization of a tracking and follow-up system to provide comprehensive oversight of high risk patients/families
- Increase centralized staffing, as well as distributed ED, specialty clinic and hospital staffing, to support the overall program
- Utilize 24/7 clinical call center and outreach system using multiple modalities to connect with and message patients/families
- Utilize community resource centers to educate/train patients and families in group settings to self-manage clinical conditions, adopt new health and medical behaviors, use social networking to support behavior change and provide very specific education programs using community resources.

Children's Medical Center (CMC) will develop and utilize a high-intensity, culturally appropriate case management system for children and families who utilize or are referred to CMC facilities and services. The high intensity case management system will follow patients and families across the continuum of care, both within CMC and throughout the community and home settings.

Goals and Relationship to Regional Goals

Optimization of care coordination and delivery will improve access, reduce costs, improve linkages with primary care providers, reduce avoidable ED utilization and hospitalizations,

improve access to chronic care management and improve education of providers and caregivers in effective care management.

This project is related to the regional goals of improving access to primary and preventive care, decreasing potentially avoidable admissions, decreasing potentially avoidable readmissions, decreasing potentially avoidable complications, increasing self-management skills, increasing adherence to self-care plans and increasing the availability of primary and preventive services.

Challenges

A major challenge will be the installation and implementation of the IT support system to enable the ability to integrate all providers for a patient/family, to respond in a timely manner and to identify high risk individuals out of a total population for intensive, timely follow-up. A well-defined and structured implementation plan will be important to meeting this challenge.

5-year Expected Outcomes for Provider and Patients

Five-year expected outcomes include reduction in low complexity ED visits, reduction in potentially avoidable admissions, reduction in potentially avoidable readmissions, reduction in potentially avoidable complications, increase in adherence to self-care plans and increase use of primary and preventive services

Starting Point/Baseline:

Baseline numbers will be established during DY2.

Rationale

Implementation of this project is expected to improve identification of high risk patients, create comprehensive care management plans across various community-based providers, educate patients/families, track and follow up patient trajectories and thereby reduces avoidable ED visits, reduce avoidable specialty clinic visits, reduce avoidable admissions and readmissions, and improve family self-management and health of children.

According to Regional Health Partnership IX Community Needs Assessment Report, Dallas Fort Worth Hospital Council, April 2012, the demand for both primary and specialty care services exceeds that of available medical physicians in those areas; thus limiting health care access for many low level management or specialized treatment for prevalent health conditions. Additionally, many individuals in North Texas suffer from chronic diseases that present earlier in life, are becoming more prevalent, and exhibit more severe complications. Finally, emergency departments are treating high volumes of patients with preventable conditions, or conditions that are suitable to be addressed in a primary care setting. Additionally, re-admissions are higher than desired, particularly for those with severe chronic diseases or behavioral health.

According to Regional Health Partnership IX Community Needs Assessment Report, Dallas Fort Worth Hospital Council, April 2012, the impact of the limited primary and specialty care is significantly profound for children and families in the region. With the current pediatric need being more than 80% of the current supply, in rural and urban areas the demand for primary care services is much higher than the current supply. In Dallas County alone, over 36.2% of children were enrolled in Medicaid in 2010, exacerbating the issue of availability of primary care access and treatment. Additionally, data indicates that many of the pediatric specialists are limited, creating a backlogged pipeline for those needing specialty services after seeking primary care.

Medicaid and safety net patients have avoidable emergency department (ED) visits, specialty visits and hospitalizations for the exacerbation of acute and chronic conditions due to the lack of intensive case management, care navigation and care transitions that follow patients and families across the care continuum. Patients and families who do not have established, culturally appropriate systems and pathways of access for management or worsening of symptoms, or the transition from one care setting to another, often turn to emergency departments. Primary or specialty providers, who do not have access to a high intensity case management system, often utilize the most expensive services by referring patients to this care. Additionally, providers often do not understand the importance of care navigation and care transition support. Frequently, patients and families leave the ED, a specialty clinic or a hospital not understanding what was done to them when they were treated and how to care for themselves once released. This lack of knowledge frequently causes patients to be seen again in the ED or readmitted, causing needless suffering and preventable health care costs. Patients with complex social and medical problems, who represent a significant portion of patients in safety net EDs or hospitals, are at particularly high risk for readmission and poor health status. Children's Medical Center is the safety net hospital for children in Dallas County, providing the majority of ED, specialty and inpatient care to Medicaid and safety net patients/families. Identification of at-risk patients/families, development/implementation of care management plans across the continuum of care, effective and culturally appropriate patient/family education, communication with the patient's primary care physician, and tracking/follow-up of patients across the care continuum will ensure a closed-loop program for Medicaid and safety net children and families. The project will reach approximately 44,000 unique patients.

Project Components

Components of this project include:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Health care navigators will be trained in cultural competency as well as come from culturally diverse backgrounds.
b) Deploy innovative health care personnel as patient navigators.
c) Connect patients to primary and preventive care.

d) Increase access to care management and/or chronic care management including education in chronic disease management.
e) Conduct quality improvement for this project using methods such as rapid cycle improvement.

All project components were selected because they will assist in the successful implementation of the project.

Unique community need (CN) identification number the project addresses:

CN 3: Healthcare capacity
CN 4: Primary Care and Pediatrics
CN 8: Chronic Disease
CN 9: Specialty Care
CN 12: Emergency Department Usage and Readmissions

How the Project significantly enhances and existing delivery system reform initiative

This project represents a new initiative for Children's Medical Center. This project is data driven and addresses areas of poor performance (overuse of ED services and inpatient services) and a disparity group ('safety net' children).

Related Category 3 Outcome Measures

OD-9 Preventive and Primary Care. IT-9.2 ED appropriate utilization (Stand-alone measure) This measure was selected because the project is designed to support appropriate utilization of ED services and improve the health of low-income children. This project will target specific intervention for families who routinely use the Emergency Department for low complexity and primary care. By providing education and assistance in securing a medical home, these families' use of the Emergency Department should decrease.

Reasons/Rationale for selecting outcome measures
The project is designed to support appropriate utilization of ED services and improve the health of low-income children.

Relationship to other projects
Other related Children's Medical Center projects include:

138910807.1.1 Expand pediatric primary care capacity
138910807.1.2 Expand pediatric primary care hours
138910807.1.3 Implement and utilize pediatric-specific disease management system
138910807.1.4 Expand pediatric behavioral health capacity
138910807.2.1 Enhance/Expand pediatric medical homes

138910807.2.2 Implement Evidence-based Health Promotions Program
138910807.2.4 Implement/expand care transitions program

This project will support care delivery being developed to navigate patients into primary care medical home settings as well as assist pediatric patients as they transition to adult providers.

Related Category 4 Population-focused improvements:

RD-1: Potentially Preventable Admissions (PPA)

Relationship to Other Performing Providers' Projects in the RHP

The RHP 9 projects to enhance patient navigation programs include the following:

Performing Provider	Unique Project
Baylor Medical Center at Garland	121790303.2.3
Baylor Medical Center at Irving	121776204.2.3
Baylor University Medical Center	139485012.2.1
Medical Center of Lewisville (HCA)	094192402.2.3
Methodist Charlton Medical Center	126679303.2.2
Methodist Dallas Medical Center	135032405.2.1
Methodist Richardson Medical Center	209345201.2.1
Parkland Health & Hospital System	127295703.2.7
Texas Health Presbyterian – Denton	020967801.2.1
Texas Health Presbyterian – Kaufman	094140302.2.1
University of Texas Southwestern – Faculty	126686802.2.4
University of Texas Southwesten – Hospital	175287501.2.1

Learning Collaborative. We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

This project was valued using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	9	1.80
Population Served / Project Size	25%	8	2.00
Alignment with Community Needs	20%	8	1.60
Cost Avoidance	15%	8	1.20

Sustainability	15%	9	1.35
Partnership Collaboration	5%	7	0.35
	100%		8.30

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact

Moderate Weakness: Lessens impact

Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

The project will not use additional federal grant dollars.

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3. Fisher TL, Burnet DL, Huang ES, Chin MH, Cagney KA. Cultural leverage: interventions using culture to narrow racial disparities in health care. Med Care Res Rev. 2007 Oct;64(5 Suppl):243S-82S.

138910807.2.3	***2.9.1***	***2.9.1 (A-E)***	***ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM***	
Children's Medical Center				*138910807*
Related Category 3 Outcome Measure(s):	*138910807.3.7*	*IT-9.2*	*ED appropriate utilization (Stand-alone measure)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. P-1.1. Metric: Provide report identifying the following: a. Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy). b. Gaps in services and service needs. c. How program will identify, triage and manage target population (i.e. Policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts). d. Ideal number of patients targeted for enrollment in the patient navigation program e. Number of Patient Navigators needed to be hired f. Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients h. Data Source: Program documentation, EHR, claims, needs	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. P-2.3. Metric: Frequency of contact with care navigators for high risk patients. a. Numerator: Number of care navigation encounters b. Denominator: Number of unique patients enrolled in patient navigation program. c. Data Source: Patient navigation program materials and database, EHR d. Rationale/Evidence: Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions e. Goal: Average of 2 contacts per patient in navigation program 30,000 unique patients by 9/30/2014 Milestone 3 P2 Estimated Incentive Payment (maximum amount): $1,150,853	Milestone 6 (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. Especially for disenfranchised or medically complex patients, navigation is about guiding people through and across the healthcare system, from provider to provider, ensuring they can get to and make multiple appointments, get prescriptions filled, access to community services for people with special needs, etc. the patient navigator represents the liaison between primary, secondary, tertiary and quaternary health care. P-5.1. Metric: Collect and report on all the types of patient navigator services provided. a. Data Source: electronic Health Record b. Rationale/Evidence: Patient Navigators are intended to help patients and their caregivers interact with various departments and processes within the health care system. Developing a report of the	Milestone 8 (I-6): Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. I-6.1. Metric: Increase medical home empanelment of patients referred from navigator program. a. Numerator: Number of new patients referred for services from Patient Navigator Program that are seen in primary care setting and empanelled to the medical home. b. Denominator: Number of new patients referred for services from Patient Navigator Program. c. Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program. d. Rationale: Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions. Tying inpatient and outpatient care can help integrate inpatient and outpatient services and promote accountability for the coordination, cost and quality of care.

138910807.2.3	2.9.1	2.9.1 (A-E)	ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM	
Children's Medical Center				138910807
Related Category 3 Outcome Measure(s):	138910807.3.7	IT-9.2	ED appropriate utilization (Stand-alone 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)
assessment survey i. Rationale/Evidence: Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions. j. Goal: Needs assessment completed by 9/30/13 Milestone 1 P-1 Estimated Incentive Payment (maximum amount): $1,687,860 Milestone 2 (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 care142 including program to train the navigators, develop procedures and establish continuing navigator education. P-2.1. Metric: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. a. Data source: Workforce development plan for patient navigator recruitment, training and education	Milestone 4 (P-3): Provide care management/navigation services to targeted patients. P-3.1. Metric: Increase in the number or percent of targeted patients enrolled in the program a. Numerator: Number of targeted patients enrolled in the program b. Denominator: Total number of targeted patients identified c. Data Source: Enrollment reports d. Rationale/Evidence: Ineffective navigation of the health care system by patients may lead to poorer outcomes and inefficiencies because of delayed care, failure to receive proper care or treatments, or care being received in more expensive locations (i.e., emergency rooms).144 e. Goal: 25% of targeted patients enrolled in the program 7,500 unique patients Milestone 4: P.3 Estimated Incentive Payment *(maximum amount):* $1,150,853 Milestone 5 (P-4): Increase patient engagement, such as through patient education, self-management support,	most prevalent types of services provided will allow the performing providers to tailor the services provided based upon patient needs. Reports on these types of activities could include frequency of primary care referrals, coordination with specialist care, diagnostic services, social services, pharmacy services, patient educations services and peer support networks. c. Goal: Report developed by 9/30/15 Milestone 6: P.5 Estimated Incentive Payment *(maximum amount):* $ $1,723,603 Milestone 7 (I-6): Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. I-6.2. Metric: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED a. Numerator: Number ED patients without a PCP documented in their medical record that receive (documented) education or resources to identify a PCP from a patient navigator. b. Denominator: ED patients without a	e. Goal: 75% of patients without a PCP at time of ED visit receive a referral to a PCP, 15,750 unique patients by 9/30/2016 Milestone 8: P.6 Estimated Incentive Payment *(maximum amount):* $ 2,783,458

138910807.2.3	***2.9.1***	***2.9.1 (A-E)***	***ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM***	
Children's Medical Center				*138910807*
Related Category 3 Outcome Measure(s):	*138910807.3.7*	*IT-9.2*	*ED appropriate utilization (Stand-alone 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)**
b. Rationale: A navigator's education and skill level are main determinants of the cost of patient navigation. Education, a typical gauge for salary, can range from a peer educator recruited from the community and trained in a clinical setting to an oncology research nurse with a graduate degree. c. Goal: Two patient navigators hired and trained by 9/30/13 Milestone 2: P-2 estimated payment $1,687,860	improved patient-provider communication techniques, and/or coordination with community resources P-4.1. Metric: Number of classes and/or initiations offered, or number or percent of patients enrolled in the program a. Numerator: Number of patients enrolled in patient engagement programs b. Denominator: Number of patients eligible to participate in engagement programs, as determined by provider. c. Data Source: May vary, such as class participant lists d. Rationale/Evidence: 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 e. Goal: 25% of enrolled patients and families 7,500 unique patients) participate in patient engagement activities Milestone 5: P.4 Estimated Incentive Payment *(maximum amount):* $1,150,852		PCP documented in their medical record. c. Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program. d. Rationale: Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions. Tying inpatient and outpatient care can help integrate inpatient and outpatient services and promote accountability for the coordination, cost and quality of care. e. Goal:50% of patients without a PCP at time of ED visit receive a referral to a PCP 10,500 unique patients Milestone 7: I.6 Estimated Incentive Payment *(maximum amount):* $ $1,723,603	

138910807.2.3	***2.9.1***	***2.9.1 (A-E)***	***ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM***	
Children's Medical Center				*138910807*
Related Category 3 Outcome Measure(s):	*138910807.3.7*	*IT-9.2*	*ED appropriate utilization (Stand-alone 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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 3,375,720	Year 3 Estimated Milestone Bundle Amount: $3,452,558		Year 4 Estimated Milestone Bundle Amount: $3,447,206	Year 5 Estimated Milestone Bundle Amount: $2,783,458
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 13,058,942				

Project Option 2.12.2 - Implement/Expand Care Transitions Programs

RHP Project Identifier: 138910807.2.4
Performing Provider Name/TPI: Children's Medical Center/138910807

Provider: Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine. Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. Annually, Children's has approximately 600,000 patient contacts.

Provider's role in region's health care infrastructure: Children's has the largest market share for pediatrics in DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured). Children's is considered the safety net hospital for pediatrics in region.

Intervention: A standardized approach to transitioning an adolescent with special health care needs or at risk for loss of medical services will be developed and applied to multiple medical and social conditions of the patient and family. The plan will be customizable as needed but contain a standardized approach to the transition process.

Need for the Project: The need for this project is documented in the community needs (CN) assessment, specifically: CN. 2 Regional Healthcare Infrastructure and Patient Migration Patterns, CN. 3 Healthcare capacity, CN. 4: Primary Care and Pediatrics, CN 8: Chronic Disease, CN. 9: Specialty Care and CN. 12 Emergency Department Usage and Readmissions.

Target Population: The target population is children with special health care needs aging out of the pediatric system needing to transition to adult providers. There are approximately 3,000 patients annually. The transition process will begin at age 14 so that approximately 16,000 patients are in the project in DY3.

	DY3	DY4	DY5
Patients in transition program	16,000	17,000	17,500
Approximately 65% Medicaid, CHIP, uninsured	10,700	11,000	11,300

What is the project's benefit for Medicaid and Uninsured of your Service area? Children's Medical Center is the safety net hospital for children in Dallas County, providing the majority of ED, specialty and inpatient care to Medicaid and safety net patients/families. Identification of at-risk patients/families, development/implementation of care management plans across the continuum of care, effective and culturally appropriate patient/family education, communication with the patient's primary care physician, and tracking/follow-up of patients

across the care continuum will ensure a closed-loop program for Medicaid and safety net children and families.

Category 1 & 2 Expected Benefit: Process and improvement milestones were selected to support the successful implementation of the project.

Category 3 Outcome: OD-9 Preventive and Primary Care. IT-9.2 ED appropriate utilization (Stand-alone measure). This measure was selected because the project is designed to support appropriate utilization of ED services. Historically, these patients have continued to use Children's ED services after they have aged out pediatric care.
This project is not supported by other federal grants.

Project Option 2.12.2 - Implement/Expand Care Transitions Programs
Project Description
A standardized approach to transitioning an adolescent with special health care needs or at risk for loss of medical services will be developed and applied to multiple medical and social conditions of the patient and family. The plan will be customizable as needed but contain a standardized approach to the transition process. Children's Medical Center and Texas Scottish Rite Hospital for Children will develop and implement a planned healthcare transition program for children with chronic medical conditions or who are at risk for loss of medical services as they transition from adolescence to adulthood. The process will begin at age 14 with additional training and activities each year until the patient turns 18 and is either transitioned to adult providers or determined to stay with their pediatric specialists (such as late stage muscular dystrophy patients, cancer patients in active treatment). Total number of patients in the transition program in a year (ages 14 through 18) is 16,000 patients.

Goals and Relationship to Regional Goals

The goals of this project are to establish a process to systematically address learning needs as children approach adulthood with chronic illness and to establish strong linkages to adult providers so that young adults do not experience a break in the continuity of care as they transition from pediatric providers to adult providers as they age out of pediatric care. This project is related to the regional goals of improving access to primary and preventive care, decreasing potentially avoidable admissions, decreasing potentially avoidable readmissions, decreasing potentially avoidable complications, increasing self-management skills, increasing adherence to self-care plans and increasing the availability of primary and preventive services.

Challenges

There are challenges to implementing this project. There are limited number of adult providers who can manage adults with childhood chronic disease as well as limited number of primary care providers. Some adults with complex chronic conditions acquired in childhood will require assistance from a third party to make decisions for them. By providing a standardized approach to transitioning adolescents

into adult programs, establishing referral relationships with adult providers and partnering with the RHP's adult providers who are expanding access to health care through the development of My Medical Home, the impact of these challenges will be significantly reduced.

5-year Expected Outcomes for Provider and Patients

Five-year expected outcomes include reduction in low complexity ED visits, reduction in potentially avoidable admissions, reduction in potentially avoidable readmissions, reduction in potentially avoidable complications, increase in adherence to self-care plans and increase use of primary and preventive services.

Starting Point/Baseline

Baseline numbers will be established in DY2.

Rationale

According to Regional Health Partnership IX Community Needs Assessment Report, Dallas Fort Worth Hospital Council, April 2012, many individuals in North Texas suffer from chronic diseases that present earlier in life, including many children who suffer from chronic diseases that are becoming more prevalent and exhibit more severe complications. In 2002, a consensus statement coauthored by the American Academy of Pediatrics, the American Academy of Family Physicians and the American College of Physicians-American Society of Internal Medicine emphasized the importance of active engagement in the transition of adolescents with special health care needs into adulthood. A follow-up report in 2011 stated that wide-spread implementation of health transition programs has not occurred.

When a patient's transition is less than optimal, the repercussions can be serious: avoidable hospital admission, unnecessary emergency department visits, escalation of severity of the condition and development of additional co-morbidities. Adult primary care providers are challenged in providing care to young adults who have not been prepared to be their own health advocate and who do not understand their own medical history and conditions. The 2007 AAP Annual Leadership Forum developed a resolution stating "transitioning youth with special health care needs to adult health care" as a top-10 priority. Providing support to transition adolescents with special health care needs and/or those at risk for loss of medical services is imperative in the development of a comprehensive continuum of care of which promotes health and appropriate management of chronic conditions. The transition program will increase opportunities to prevent disease and minimize unnecessary exacerbation of chronic illness.

Project Components

There are no core components for Project 2.12.2. The milestone and metrics for this project are based on the relevancy to the RHP 9's population, the community needs, RHP priority (this project was rated the second highest priority level by the participating providers in the RHP), and the current state (starting point).

Unique community need (CN) identification number the project addresses:

CN.2 Regional Healthcare Infrastructure and Patient Migration Patterns
CN.3 Healthcare Capacity
CN.4 Primary Care and Pediatrics
CN.8 Chronic Disease
CN.9 Specialty Care
CN.12 Emergency Department Usage and Readmissions

How the project significantly enhances and existing delivery system reform initiative

This project represents a new initiative for Children's Medical Center. This project is data driven and addresses areas of poor performance (overuse of ED services and inpatient services) and a disparity group (Children with chronic medical conditions aging out of pediatric care services).

Related Category 3 Outcome Measures

OD-9 Right Care, Right Setting
IT-9.2 ED appropriate utilization (Stand-alone measure)

This measure was selected because the project is designed to provide a transition to adult care and reduce inappropriate utilization of ED services. Currently, former pediatric patients who do not successfully transition to adult providers return to Children's Emergency Department for care. In 2012, there were 38 patients between the ages of 18 and 19 who used Children's Emergency Department 157 times, averaging 4.13 visits per patient. By providing a better transition plan for these patients, this number of inappropriate visits should decrease for this patient population.

Relationship to other projects

Other Children's Medical Center projects include:

139810807.1.1	Expand Primary Care Capacity
138910807.1.2	Expand Primary Care Hours
138910807.1.3	Implement Disease Management
138910807.1.4	Expand Pediatric Behavioral Health
138910807.2.1	Expand Medical Homes
138910807.2.2	Implement/Enhance Evidence-based Health Promotion Programs
138910807.2.3	Expand/Enhance Patient/Family Navigation

The projects listed above, when fully implemented, will assist in identifying patients aging out of pediatric care who need assistance in transitioning to adult providers.

Related Category 4 Population-focused improvements

RD-1 Potentially Preventable Admissions
RD-2 30-day readmissions
RD-3 Potentially Preventable Complications
RD-6 Initial Core Set of Health Care Quality Indicators

As appropriate care transition occurs, overall population health metrics should improve.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative
Other performig provider related projects inclue:

Performing Provider	Unique Project Number
Baylor Medical Center at Garland	121790303.2.4
Baylor Medical Center at Irving	121776204.2.4
Children's Medical Center	138910807.2.4
Doctors Hospital at White Rock (Tenet)	094194002.2.2
Parkland Health & Hospital System	127295703.2.9
University of Texas Southwestern – Faculty	126686802.2.5
University of Texas Southwestern – Hospital	175287501.2.3

Plan for Learning Collaborative. We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation
This project was valued using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	7	1.40
Population Served / Project Size	25%	5	1.25
Alignment with Community Needs	20%	6	1.20
Cost Avoidance	15%	6	0.90
Sustainability	15%	8	1.20

Partnership Collaboration	5%	9	0.45
	100%		6.40

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact
Moderate Weakness: Lessens impact
Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

This project is not supported by other federal grants.

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1. Harden PN, Walsh G, Bandler N, Bradley S, Lonsdale D, Taylor J, Marks SD. Bridging the gap: an integrated paediatric to adult clinical service for young adults with kidney failure. BMJ. 2012 Jun 1;344:e3718. doi: 10.1136/bmj.e3718.
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4. Goudie A, Carle AC. Ohio study shows that insurance coverage is critical for children with special health care needs as they transition to adulthood. Health Aff (Millwood). 2011 Dec;30(12):2382-90.

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138910807.2.4	*2.12.2*	***PROJECT COMPONENTS:*** *NA*	*IMPLEMENT/EXPAND CARE TRANSITION PROGRAMS*
Children's Medical Center			*138910807*
Related Category 3 Outcome Measure(s):	*138910807.3.8*	*IT-9.2*	*ED appropriate utilization (Stand-alone 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-4): Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge P-4.1. Metric: Care transitions assessment a. Submission of care transitions assessment and resource planning documents b. Data Source: Care transitions assessment and resource planning documents c. Rationale/Evidence: It is important to try to coordinate care with facilities outside a provider's own delivery system so that patients going in and out of the delivery system can receive optimal care, wherever possible. The Community Based Care Transitions Program is an example of this innovative work. d. Goal: Needs assessment completed 9/30/13 Milestone 1: P.4 Estimated Incentive Payment *(maximum amount):* $1,296,819 Milestone 2 (P-7): Develop a staffing and implementation plan to	Milestone 3 (P-1): Develop or implement best practices or evidence-based protocols (such as Partnership for Patients) for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions P-1.1. Metric: Care transitions protocols a. Submission of protocols b. Data Source: Submission of protocols, Care transitions program materials c. Rationale/Evidence: Protocols for discharge planning and post discharge follow-up will allow for wider and more affective system adoption of new practices. d. Goal: Develop protocols by 9/30/14 Milestone 3 P1 Estimated Incentive Payment *(maximum amount):* $1,326,337 Milestone 4 (P-2): Implement standardized care transition processes P-2.1. Metric: Care transitions policies	Milestone 5 (I-10): Identify the top chronic conditions (e.g., heart attack, heart failure and pneumonia) and other patient characteristics (e.g., medical home assignment and demographics such as age) or socioeconomic factors (e.g., homelessness) that are common causes of avoidable readmissions I-10.1. Metric: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-admissions. a. List by frequency of most prevalent chronic conditions, patient factor or other socioeconomic factors in patient panel resulting in highest readmission rates. b. Data Source: Registry or EHR report/analysis c. Rationale/Evidence: Assessing the most prevalent conditions and factors that lead to re-admissions will allow the provider to address the needs of the patient population more effectively. d. Goal: Top chronic conditions identified by 9/30/15	Milestone 7 (I-14): Implement standard care transition processes in specified patient populations. I-14.1. Metric: Measure adherence to processes. a. Numerator: Number of patients in defined population receiving care according to standard protocol. b. Denominator: Number of population patients discharged. c. Data Source: Hospital administrative data and the patient medical record. **d.** Goal: 50% of identified patients receiving care according to standard protocol. 5,650 unique patients Milestone 6: I-14 Estimated Incentive Payment *(maximum)* $2,138,590

138910807.2.4	*2.12.2*	***PROJECT COMPONENTS:*** *NA*	*IMPLEMENT/EXPAND CARE TRANSITION PROGRAMS*
Children's Medical Center			*138910807*
Related Category 3 Outcome Measure(s):	*138910807.3.8*	*IT-9.2*	*ED appropriate utilization (Stand-alone 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)**
accomplish the goals/objectives of the care transitions program P-7.1. Metric: Documentation of the staffing plan. a. Data Source: Staffing and implementation plan. b. Rationale/Evidence: This describes the number and types of staff needed and the specific roles of each participant c. Goal: Staffing plan developed by 9/30/13 Milestone 2: P.7 Estimated Incentive Payment *(maximum amount):* $1,296,819	and procedures a. Submission of protocols, b. Data Source: Policies and procedures of care transitions program materials c. Rationale/Evidence: In order to allow for system adoption of care transition processes, it is critical to develop policies and procedures identifying responsible parties, activities, timelines and anticipated outcomes related to a successful discharge and follow-up care. d. Goal: Processes implemented by 9/30/14 Milestone 4 P2 Estimated Incentive Payment *(maximum amount):* $1,326,337	Milestone 5 I- 10 Estimated Incentive Payment *(maximum amount):* $ 1,324,281 Milestone 6 (I-14): Implement standard care transition processes in specified patient populations. I-14.1. Metric: Measure adherence to processes. a. Numerator: Number of patients in defined population receiving care according to standard protocol. b. Denominator: Number of population patients discharged. c. Data Source: Hospital administrative data and the patient medical record. **d.** Goal: 25% of identified patients receiving care according to standard protocol. 2,750 unique patients Milestone 6: I-14 Estimated Incentive Payment *(maximum amount):* $1,324,281	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,593,638	Year 3 Estimated Milestone Bundle Amount: $2,652,674	Year 4 Estimated Milestone Bundle Amount: $2,648,562	Year 5 Estimated Milestone Bundle Amount: $2,138,590
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $10,033,464			

Project Option 2.6.2 – Establish self-management programs and wellness using evidence-based designs (Disease Outbreaks and Sentinel Events Education)

Unique Project ID: 121758005.2.1
Performing Provider Name/TPI: Dallas County Health and Human Services/121758005

Provider: The mission of the Dallas County Department of Health and Human Services (DCHHS) is to protect the health of the citizens of Dallas County through disease prevention and intervention, and through promotion of a healthy community and environment. DCHHS serves a population of 2.4 million persons through outpatient health programs primarily focusing on communicable diseases. The health department has a staff of approximately 300; and workload measures include 24,486 STD clinic visits, 824 HIV clinic visits, and 16,967 TB clinic visits. As a public health contributor to this waiver proposal, DCHHS has also received reports of 11,310 communicable disease cases and administered 127,181 vaccines to children. The Texas Department of State Health Services Public Health Funding and Policy Committee encouraged local health authorities (DCHHS) to work with their regional anchors to be included in their respective 1115 waiver regional healthcare planning initiatives. Our public health QI initiatives align with our service capacity and have been designed as best as possible to fit the hospital-based 1115 waiver metrics and outcomes.

Project Description: Implement new evidence-based health promotion for disease prevention for persons living with preventable conditions (STDs, TB, etc.). This project will involve the dissemination of information on disease prevention and DCHHS services. The goal is to expand access to health promotion to increase community awareness of disease risks and health screenings.

The interventions will be based on CQI implementation techniques that test health promotion strategies using the Plan-Do-Check-Act (PDCA) CQI Deming Cycle (PDCA Cycle, American Society for Quality, 2012). Using PDCA, a specific guide for locally appropriate health promotion strategies will be developed, tested using pre and post participant assessments, incrementally adjusted and implemented at an increasing number of community sites throughout the project years (The ABCs of PDCA, National Association of County and City Health Officials, 2011). The Year 2 and 3 health promotion interventions that display the best participant responses regarding intended behavior change to seek clinical preventive services will be implemented in Years 4 and 5.

The evidence-base of the health promotion strategies to be tested will rely on the frameworks presented in NIH Making Health Communication Programs Work (2008). Pre and post participant assessment questions will be based on NIH Theory at a Glance, Stages of Change (2009) and NIH Theory at a Glance Theory of Planned Behavior (2009) to determine if participants are more or less likely to seek screening services and improve their health behaviors regarding preventable conditions. The Year 2 and 3 health promotion interventions

that display the best participant responses regarding intended behavior change will be implemented in Years 4 and 5.

Need for the Project: *CN.3 Healthcare Capacity.* Health promotion strategies to increase awareness of disease risk and clinical preventive services encourage decreased utilization of unnecessary specialty or emergency care in the future. This is a new QI initiative, as DCHHS currently does not have any health educator positions for this purpose. Dallas County's incidence of reportable infectious diseases is lower than the Texas average, but incidence of sexually transmitted diseases is higher than found throughout the State (e.g. Chlamydia 39% higher, Gonorrhea 71% higher). Dallas County's tuberculosis rate is higher than Texas overall (Rate: 8.4/100,000). In general, these conditions are both communicable and chronic as new technologies support extended life spans, treatment, or cures among those with diagnoses (HORIZONS: The Dallas County Community Health Needs Assessment (2012). Therefore, the need for this project is to reduce preventable hospitalizations relating to these conditions.

Target Population: This project will serve residents in areas of high communicable disease incidence to inform them of disease risks and screening opportunities. The estimated number of participants will be 840 indigent or uninsured clients across all DSRIP years (at least 10 per site estimate). DCHHS collect epidemiologic data at the ZIP code level to determine priority communities for health education. The number of sites where health education for screening takes place will increase by year, starting at 12 local community sites (e.g. churches, recreation centers, etc.), then 18, 24, and 30 sites in the following DSRIP years. 75215 and 75216 are at the highest risk for health disparities (Community Need Index, Dignity Health, 2012).

Category 2 Patient Benefits: The project seeks to implement innovative health education plans to increase awareness of screening resources. New ideas, practices, and tools based in the Diffusion of Innovation public health theory, CQI principles, and evidence-based best practices will be tested in DY2 and DY3, and adopted as official practice in DY4 and DY5.

Category 3 Outcomes: Health promotion of screening services offered at DCHHS and throughout the community supports our functionality as a health department offering outpatient screening services to decrease disease transmission. The public health planning, CQI approach, and pre/post survey design will evaluate Category 3 knowledge and intent regarding behaviors/services IT12.5, IT-11.2 and IT-11.3 with discrete questions in these areas, including the intended facility in the regional partnership (or otherwise) to obtain the services. In summary, DCHHS will serve as the performing provider to address the following Category 3 outcomes: 121758005.3.3 and 121758005.3.4 and 121758005.3.8.

Project Description

Dallas County will disseminate information on current and/or prior disease outbreaks and public health preparedness in Dallas County. This project will promote preventive screenings, decreases public impact, and decrease potential healthcare treatment costs in the event of an outbreak or public health preparedness response.

Goals and Relationship to Regional Goals

The goal is to expand access to health promotion and disease prevention behavior to increase community awareness of disease risk and health screenings for outbreaks.

This project will increase community access to health information on disease prevention and thus meets the regional goal of coordinating care beginning with preventive education that will promote health awareness and possibly reduce unnecessary care.

Learning Collaborative

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Challenges

The major challenges in implementing health promotion programs include: 1. Attributing health behavior changes to specific health promotion efforts versus the environment, 2. Monitoring longitudinal adherence to new health behaviors, such as seeking screening, 3. Correlating specific health promotion efforts with disease data trends that often take up to ten years to evolve and confirm. Pre- and post-test administration proposed in this project can address the first challenge, and offer an opportunity to consider the second challenge. The third challenge cannot serve as a deterrent to health promotion, because without initiating the promotion, the disease trends would remain unchanged. Additional administrative challenges for this QI initiative include accessing community members in underserved areas or having limited access to transportation, technology, media, and other typical means of communication for health screening information.

5-Year Expected Outcome for Provider and Patients

Expanded health information access will increase real-time awareness of screening, treatment, and risk among the underserved communities and throughout the county.

Starting Point/Baseline

This program has not begun, thus the starting point is '0'.

Rationale

Dallas County has recently experienced several conditions requiring public health preparedness. Educating the community on these past and potential future circumstances can mitigate community risk and promote rapid response and health screenings. Disease management emphasizes prevention of disease-related exacerbations and complications using evidence-based guidelines and empowerment tools. It can help manage and improve the health status of a defined patient population over the entire course of a disease (HHSC, 2012).

Project Components

There are no project components for this project option.

Unique Community Need Identification Numbers the Project Addresses

CN.3 – Healthcare Capacity

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

Although information has been provided throughout the region, this will provide an opportunity for new information to be disseminated in a coordinated manner through various identified locations (identified by zip code)

Related Category 3 Outcome Measure(s)

OD-11: Addressing Health Disparities in Minority Populations

- IT-11.2: Improvement in disparate health outcomes for target population, including identification of disparity gap (Non-standalone Measure)
- IT-11.3: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (Non-standalone Measure)

OD-12: Primary Care and Primary Prevention

- IT-12.5: Other USPSTF-endorsed screening outcome measure (Non-standalone Measure)

Reason/Rationale for selecting outcome measures

Public health serves the community at-large and can educate underserved communities on disease outbreaks, thereby improving these Category 3 outcomes. The intent to adopt positive health behaviors concerning these outcomes can be evaluated in the public health education setting using pre and post assessments using Stages of Change/Theory of Planned Behavior as the public health evaluation framework. Developing health promotion programs these frameworks require new ideas, practices, tools, and solutions that can be considered a metric for progress (NIH Making Health Communication Programs Work, 2008). Upon implementation, pre- and post-assessments indicate a measure of those who have been

reached by the intervention, and also seek to determine where participants intend to seek preventive screening. Ten percent improvement from pre-assessment score to the post-assessment score indicates a the standard goal for increasing the knowledge base of the participant (American Society for State and Territorial Health Officials, Memo, 2013; CDC Healthy People 2020). DCHHS aims for this outcome improvement goal in DY5 to allow time for trials and modification upon implementation.

Relationship to Other Projects

This is a closed-loop project. There are no other projects being submitted that are related to this initiative.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

There is no other project being submitted by other performing providers that is similar to this project.

Project Valuation

The rationale for valuing the project is based on community benefit due to decreasing preventable hospitalizations. Each health promotion participant was calculated to be one less person entering into the local healthcare delivery system.

The following valuation is based on a literature review of various community health worker/health educator interventions that include economic impact analyses. The example interventions are population-based in the community setting with consistent costs, and do not include hospital-based treatment and equipment interventions that would display increased cost variability.

Valuation examples are from: Social return on investment: Community Health Workers in cancer outreach, American Cancer Society Midwest Division (2012); Community Health Workers in Massachusetts: Improving Health Care and Public Health, Massachusetts Department of Health, Office of Community Health Workers (2009); and Outcomes of Community Health Worker Interventions, Agency for Healthcare Research and Quality (2009).

The DCHHS approach for valuing the first outcome measure is based on financial and human capital resources governing the capacity of the health department to implement a health promotion program that required planning, travel, and new staff.

Unique Identifier: *121758005.2.1*	***Project Option:*** *~~2.7.1~~ 2.6.2*	***Project Components:*** *NA*	***Title:*** *Establish self-management programs and wellness using evidence-based designs*
Dallas County			*121758005*
Related Category 3 Outcome Measures :	*121758005.3.3* *121758005.3.4* *121758005.3.8*	*3.IT-11.2* *3.IT-11.3* *3.IT-12.5*	*-Improvement in disparate health outcomes for target population, including identification of disparity gap* *-Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity* *-Other USPSTF-endorsed screening outcome measures*

Year 2 (10/1/2012 – 9/30/2013)	**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] Fill health educator staff position Metric 1 [X.1] Open job requisition filled with new staff person. Data Source: Human Resources Letter of Hire **Milestone 1a** [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 Rationale: Documentation of innovational strategy and plan. Goal: Develop innovational strategy and plan based on Stage of Change/Theory of Planned Behavior, including at least 12 comprehensive strategies that apply the Spectrum of Prevention.	**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. Rationale: Documentation of implementation strategy and testing outcomes. Goal: Test 1 new idea or tool monthly from the innovational strategy, including test interventions at 18 community sites. Data Source: Documentation of Implementation (PDCA Storyboards, Pre/Post Participant Surveys) Milestone 2 Estimated Incentive Payment (max amount): $149,500	**Milestone 3** [I-6] Identify number of clients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-6.1]: Increase percentage of population reached Rationale: Test innovative intervention model variables (increased disease, risk, and screening awareness) Baseline: 180 clients Goal: 240 clients Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Milestone 3 Estimated Incentive Payment (max amount): $159,931	**Milestone 4** [I-6] Identify number of clients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-6.1]: Increase percentage of population reached Rationale: Test innovative intervention model variables (increased disease, risk, and screening awareness) Baseline: 240 clients Goal: 300 clients Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Milestone 4 Estimated Incentive Payment (max amount): $154,522

Unique Identifier: *121758005.2.1*	***Project Option:*** *~~2.7.1~~ 2.6.2*	***Project Components:*** *NA*	***Title:*** *Establish self-management programs and wellness using evidence-based designs*
Dallas County			*121758005*
Related Category 3 Outcome Measures :	*121758005.3.3* *121758005.3.4* *121758005.3.8*	*3.IT-11.2* *3.IT-11.3* *3.IT-12.5*	*-Improvement in disparate health outcomes for target population, including identification of disparity gap* *-Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity* *-Other USPSTF-endorsed screening outcome measures*

Year 2 (10/1/2012 – 9/30/2013)	**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: DCHHS evidence of innovational plan Milestone 1 Estimated Incentive Payment (max amount): $159,277			
Year 2 Estimated Milestone Bundle Amount (add incentive payment amounts from each milestone): $159,277	**Year 3 Estimated Milestone Bundle Amount:** $149,500	**Year 4 Estimated Milestone Bundle Amount:** $159,931	**Year 5 Estimated Milestone Bundle Amount:** $154,522
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):			**$ 623,230**

Project Option 2.6.2 – Establish self-management programs and wellness using evidence-based designs (STD, TB, and Immunizations Health Education)

Unique Project ID: 121758005.2.2
Performing Provider Name/TPI: Dallas County Health and Human Services/121758005

Provider: The mission of the Dallas County Department of Health and Human Services (DCHHS) is to protect the health of the citizens of Dallas County through disease prevention and intervention, and through promotion of a healthy community and environment. DCHHS serves a population of 2.4 million persons through outpatient health programs primarily focusing on communicable diseases. The health department has a staff of approximately 300; and workload measures include 24,486 STD clinic visits, 824 HIV clinic visits, and 16,967 TB clinic visits. As a public health contributor to this waiver proposal, DCHHS has also received reports of 11,310 communicable disease cases and administered 127,181 vaccines to children. The Texas Department of State Health Services Public Health Funding and Policy Committee encouraged local health authorities (DCHHS) to work with their regional anchors to be included in their respective 1115 waiver regional healthcare planning initiatives. Our public health QI initiatives align with our service capacity and have been designed as best as possible to fit the hospital-based 1115 waiver metrics and outcomes.

Project Description: Implement new evidence-based health promotion for disease prevention involving sentinel events. This project will involve the dissemination of information on current and/or prior disease outbreaks and public health preparedness in Dallas County. The goal is to expand access to health promotion to increase community awareness of disease risk and health screenings for large outbreaks that may include sentinel events.

The interventions will be based on CQI implementation techniques that test health promotion strategies using the Plan-Do-Check-Act (PDCA) CQI Deming Cycle (American Society for Quality, 2012). Using PDCA, a specific guide for locally appropriate health promotion strategies will be developed, tested using pre and post participant assessments, incrementally adjusted and implemented at an increasing number of community sites throughout the project years (National Association of County and City Health Officials, 2011). The Year 2 and 3 health promotion interventions that display the best participant responses regarding intended behavior change to seek clinical preventive services will be implemented in Years 4 and 5.
The evidence-base of the health promotion strategies to be tested will rely on the frameworks presented in NIH Making Health Communication Programs Work (2008). Pre and post participant assessment questions will be based on NIH Theory at a Glance, Stages of Change (2009) and NIH Theory at a Glance Theory of Planned Behavior (2009) to determine if participants are more or less likely to seek screening services and improve their health behaviors regarding pending outbreaks/sentinel events. The Year 2 and 3 health promotion interventions that display the best participant responses regarding intended behavior change will be implemented in Years 4 and 5.

Need for the Project: *CN.3 Healthcare Capacity*. Health promotion strategies to increase awareness of disease risk and clinical preventive services encourage decreased utilization of unnecessary specialty or emergency care in the future. This is a new QI initiative, as DCHHS currently does not have any health educator positions for this purpose. A significant outbreak of West Nile virus occurred during the summer of 2012 requiring both ground and aerial spraying to address over 300 cases (HORIZONS, 2012). Dallas County effectively implemented public health preparedness measures engaging federal, state, and local partners to monitor and control the outbreak (pending as of the date of this submission). There have also been past flu and hepatitis outbreaks that deserve attention during this QI initiative as well. Therefore, the need for this project is to reduce preventable hospitalizations relating to these conditions.

Target Population: This project will serve residents in areas of high communicable disease incidence to inform them of disease risks and screening opportunities. The estimated number of participants will be 900 indigent or uninsured clients across all DSRIP years (at least 30 per ZIP estimate). DCHHS collect epidemiologic data at the ZIP code level to determine priority communities for health education. The number of sites where health education for screening takes place will increase by year, starting within 3 ZIP codes, then 6, 9, and 12 ZIP codes in the following DSRIP years. 75215 and 75216 are at the highest risk for health disparities (Community Need Index, Dignity Health, 2012). This project requires epidemiological evidence-based targeting that will be based on high incidence ZIP codes affected by the current or past sentinel event.

Category 2 Patient Benefits: The project seeks to implement innovative health education plans to increase awareness of screening resources. New ideas, practices, and tools based in the Diffusion of Innovation public health theory, CQI principles, and evidence-based best practices will be tested in DY2 and DY3, and adopted as official practice in DY4 and DY5.

Category 3 Outcomes: Health promotion of screening services offered at DCHHS and throughout the community supports our functionality as a health department offering outpatient screening services to decrease disease transmission. As a public health contributor serving the community at-large, Dallas County will use pre and post assessment surveys from screening educational sessions will serve as the improvement milestone for screening seeking behaviors. The public health planning, CQI approach, and pre/post survey design will evaluate Category 3 knowledge and intent regarding behaviors/services IT12.5, IT-11.2 and IT-11.3 with discrete questions in these areas, including the intended facility in the regional partnership (or otherwise) to obtain the services. In summary, DCHHS will serve as the performing provider to address the following Category 3 outcomes: 121758005.3.6, 121758005.3.7, and 121758005.3.9.

Project Description

Dallas County will disseminate information on communicable disease prevention and DCHHS services.

Goals and Relationship to Regional Goals

The goal is to expand access to health promotion and disease prevention behavior to increase community awareness of disease risk and health screenings.

This project will increase community access to health information on a preventive basis, which decreases public impact and potential healthcare treatment costs in the event of an outbreak. Thus, it meets the regional goal of coordinating care beginning with preventive education that will promote health awareness and possibly reduce unnecessary care that is a sentinel event (e.g. West Nile outbreak).

Learning Collaborative:

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Challenges

The major challenges in implementing health promotion programs include: 1. Attributing health behavior changes to specific health promotion efforts versus the environment, 2. Monitoring longitudinal adherence to new health behaviors, such as seeking screening, 3. Correlating specific health promotion efforts with disease data trends that often take up to ten years to evolve and confirm. Pre- and post-test administration proposed in this project can address the first challenge, and offer an opportunity to consider the second challenge. The third challenge cannot serve as a deterrent to health promotion, because without initiating the promotion, the disease trends would remain unchanged. Additional administrative challenges for this QI initiative include accessing community members in underserved areas or having limited access to transportation, technology, media, and other typical means of communication for health screening information.

5-Year Expected Outcome for Provider and Patients

Expanded health information access will increase awareness of screening, treatment, and risk among the underserved communities and throughout the county.

Starting Point/Baseline

This program has not begun, thus the starting point is '0'.

Rationale

Dallas County has high communicable disease rates in comparison to Healthy People 2020 goals, and information on risks and screening can improve these rates. Disease management emphasizes prevention of disease-related exacerbations and complications using evidence-based guidelines and empowerment tools. It can help manage and improve the health status of a defined patient population over the entire course of a disease (HHSC, 2012).

Project Components

There are no project components for this project option.

Unique Community Need Identification Numbers the Project Addresses

CN.3 – Healthcare Capacity

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

Although information has been provided throughout the region, this will provide an opportunity for new information to be disseminated in a coordinated manner through various identified locations.

Related Category 3 Outcome Measure(s)

OD-11: Addressing Health Disparities in Minority Populations

- IT -11.2 – Improvement in disparate health outcomes for target population, including identification of the disparity gap.
- IT-11.3 – Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity.

OD-12 Primary Care and Primary Prevention

- IT-12.5 – Other USPSTF-endorsed screening outcome measure.

Reasons/Rationale for selecting outcome measures

Public health serves the community at-large and can educate underserved communities on disease outbreaks, thereby improving these Category 3 outcomes. The intent to adopt positive health behaviors concerning these outcomes can be evaluated in the public health education setting using pre and post assessments using Stages of Change/Theory of Planned Behavior as the public health evaluation framework. Developing health promotion programs these

frameworks require new ideas, practices, tools, and solutions that can be considered a metric for progress (NIH Making Health Communication Programs Work, 2008). Upon implementation, pre- and post-assessments indicate a measure of those who have been reached by the intervention, and also seek to determine where participants intend to seek preventive screening. Ten percent improvement from pre-assessment score to the post-assessment score indicates a reasonable goal for increasing the knowledge base of the participant (American Society for State and Territorial Health Officials, Memo, 2013; CDC Healthy People 2020). DCHHS aims for this outcome improvement goal in DY5 to allow time for trials and modification upon implementation.

Relationship to Other Projects

This is a closed-loop project. There are no other projects being submitted that are related to this initiative.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

There is no other project being submitted by other performing providers that is similar to this project.

Project Valuation

The rationale for valuing the project is based on community benefit due to decreasing preventable hospitalizations. Each health promotion participant was calculated to be one less person entering into the local healthcare delivery system.

The following valuation is based on a literature review of various community health worker/health educator interventions that include economic impact analyses. The example interventions are population-based in the community setting with consistent costs, and do not include hospital-based treatment and equipment interventions that would display increased cost variability.

Valuation examples are from: Social return on investment: Community Health Workers in cancer outreach, American Cancer Society Midwest Division (2012); Community Health Workers in Massachusetts: Improving Health Care and Public Health, Massachusetts Department of Health, Office of Community Health Workers (2009); and Outcomes of Community Health Worker Interventions, Agency for Healthcare Research and Quality (2009).

The DCHHS approach for valuing the first outcome measure is based on financial and human capital resources governing the capacity of the health department to implement a health promotion program that required planning, travel, and new staff.

Unique Identifier: *121758005.2.2*	***Project Option:*** *2.6.2*	***Project Components:*** *NA*		***Title:*** *Establish self-management programs and wellness using evidence-based designs*	
Dallas County					*121758005*
Related Category 3 Outcome Measures :	*121758005.3.6* *121758005.3.7* *121758005.3.5*	*3.IT-11.2* *3.IT-11.3* *3.IT-12.5*	*-Improvement in disparate health outcomes for target population, including identification of disparity gap* *-Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity* *- Other USPSTF-endorsed screening measures*		

Year 2 (10/1/2012 – 9/30/2013)	**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] Fill health educator staff position Metric 1 [X.1] Open job requisition filled with new staff person. Data Source: Human Resources Letter of Hire **Milestone 1a** [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 Rationale: Documentation of innovational strategy and plan. Goal: Develop innovational strategy and plan based on Stage of Change/Theory of Planned Behavior, including at least 12 comprehensive strategies that	**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. Rationale: Documentation of implementation strategy and testing outcomes. Goal: Test 1 new idea or tool monthly from the innovational strategy, including test interventions in 3 ZIP codes (270 clients). Data Source: Documentation of Implementation (PDCA Storyboards, Pre/Post Participant Surveys) Milestone 2 Estimated Incentive Payment (max amount): $331,191	**Milestone 3** [I-6] Identify number of clients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-6.1]: Increase percentage of population reached Rationale: Test innovative intervention model variables (increased disease, risk, and screening awareness) Baseline: 270 clients Goal: 540 clients Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Milestone 3 Estimated Incentive Payment (max amount): $356,437	**Milestone 4** [I-6] Identify number of clients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-6.1]: Increase percentage of population reached Rationale: Test innovative intervention model variables (increased disease, risk, and screening awareness) Baseline: 540 clients Goal: 900 clients Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Milestone 4 Estimated Incentive Payment (max amount): $344,383

<table>
<tr><td>Unique Identifier:
121758005.2.2</td><td>Project Option:
2.6.2</td><td colspan="2">Project Components:
NA</td><td colspan="2">Title: Establish self-management programs and wellness using evidence-based designs</td></tr>
<tr><td colspan="4">Dallas County</td><td colspan="2">121758005</td></tr>
<tr><td>Related Category 3 Outcome Measures :</td><td>121758005.3.6
121758005.3.7

121758005.3.5</td><td>3.IT-11.2
3.IT-11.3

3.IT-12.5</td><td colspan="3">-Improvement in disparate health outcomes for target population, including identification of disparity gap
-Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity
- Other USPSTF-endorsed screening measures</td></tr>
<tr><th colspan="2">Year 2
(10/1/2012 – 9/30/2013)</th><th colspan="2">Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td colspan="2">apply the Spectrum of Prevention.

Data Source: DCHHS evidence of innovational plan.

Milestone 1 Estimated Incentive Payment (max amount): $514,078</td><td colspan="2"></td><td></td><td></td></tr>
<tr><td colspan="2">Year 2 Estimated Milestone Bundle Amount: $514,078</td><td colspan="2">Year 3 Estimated Milestone Bundle Amount: $331,191</td><td>Year 4 Estimated Milestone Bundle Amount: $356,437</td><td>Year 5 Estimated Milestone Bundle Amount: $344,383</td></tr>
<tr><td colspan="5">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):</td><td>$ 1,548,089</td></tr>
</table>

Project Option 2.15.1 – Primary Care Integration

Unique Project ID: 137252607.2.1
Performing Provider Name/TPI: Dallas County MHMR Center dba Metrocare Services/ 137252607

Provider: Metrocare Services is a community-based behavioral health organization, serving approximately 50,000 persons in Dallas County with mental illness and developmental disabilities.

Interventions: This project will create an integrated model of easy, open access to primary care services for persons who are receiving behavioral health services in our community based behavioral health clinics. This effectively establishes a 'one stop shop' for patients to receive both behavioral and primary care services on the same day.

Need for the project: Persons with serious and persistent mental illnesses have life expectancies which are 25 years less than the general population. They frequently have difficulty with reliable or affordable transportation and have problems accessing and engaging in routine medical services, thereby experiencing increased morbidity and mortality. They also have increased use of local hospital emergency rooms. At present, the wait time for new patients to access primary care services at local community primary care clinics can be up to 6 months, and existing primary care clinics are often not conveniently located or easily accessible to where patients live.

Target population: The target population is Metrocare patients who are diagnosed with a severe and persistent mental illness as defined by the Texas Department of State Health Services, who are enrolled in community mental health services and who are in need of primary care services in an integrated behavioral and primary health care setting.

Category 1 or 2 expected patient benefits: The goals of this project include:
- Increase numbers of patients receiving integrated behavioral and physical healthcare services during each year of the project (DY 2-500; DY 3-1500; DY 4-1200; DY 5-3500)
-Increase the percentage of patients who report satisfaction with integrated services at Metrocare community clinics as measured by the Consumer Assessment of Healthcare Providers and Systems (DY 2-60%; DY 3-70%; DY 4-80%; DY 5-90%)

Category 3 outcomes: The goals of this project include:
-Improved performance measures on HEDIS criteria for diabetes, HTN, CAD, COPD/Asthma, and smoking cessation
-Increased preventive care utilizations for persons with mental illnesses, including increased Immunization rates, improved breast, colon, cervical and prostate cancer screenings
-Decreased use of emergency departments
-Decreased hospitalization rates

-Decreased per capita health care costs

Project Description

Expand the availability of integrated behavioral and physical healthcare to persons with severe and persistent mental illnesses in community mental health clinics.

As identified in the Community Needs Assessment for Region 9, a number of medical diagnoses which account for high volumes and frequent visits to emergency departments are either preventable or treatable in a lesser acute environment. The report also indicates that persons with severe mental illnesses are less likely to access regular care and are likely to receive a lesser quality of medical care (Collins, 2012. RHP 9: Community Needs Assessment Report). This project will establish a total of four integrated behavioral and physical healthcare clinics by Year 5 of the project and is expected to provide integrated behavioral and physical healthcare services to 3500 person by Year 5 of the project. These clinics will be staffed with psychiatrists, primary care physicians, Advanced Nurse Practitioners who are cross-trained in behavioral and physical healthcare, RN's, LVNs/medical assistants, Licensed Professional Counselors/Licensed Clinical Social Workers, Licensed Chemical Dependency Counselors, and case management staff.

Goals and Relationship to Regional Goals

The goal of this project is to expand medical care to persons with severe and persistent mental illnesses in an integrated, easily accessible environment where both behavioral and physical health practitioners have input into treatment planning and access to relevant information which may have impact on a patient's mental and physical well-being. The Region 9 Community Needs Assessment reports that the top 10 utilizers of emergency services in Region 9, in 2011, all had diagnoses of mental illness, but none presented to emergency departments with chief complaints related to their mental illnesses. In Dallas County, the presence of a "co-occurring behavioral health condition is associated with increased case severity of medical encounters and a 36% in the average charges per encounter." (Collins, 2012). By establishing community clinics which integrate behavioral and physical health care, there is the opportunity for improved communication between mental and physical healthcare providers, allowing the team to intervene in medical or behavioral illnesses before a higher level of care is necessary, as well as providing the patient an easily accessible alternative to the use of emergency services. Establishment of integrated community clinics would result in less frequent use of emergency services and decreased healthcare service costs to the Region

Challenges

- The Region 9 Community Needs Assessment (Collins, 2012) indicates that Region 9 is below average in the number of primary care physicians. Hiring and retaining primary

care physicians is expected to become a greater challenge over the next several years, as competition for these providers increases.

- Development of an adequate, easy to access medical specialty referral base
- Establishment of providers for laboratory and other diagnostic services
- Engagement of persons with serious and persistent mental illnesses in preventive care practices
- Engagement and facilitation of having patients utilize community integrated services as alternative to the utilization of more acute levels of care

5-Year Expected Outcome for Provider and Patients

- Improved performance measures on HEDIS criteria for Diabetes, HTN, CAD, COPD/ Asthma, Smoking cessation etc.
- Increased preventive care utilizations such as increased preventive care immunization rates in the MH clients, improved breast, colon and cervical cancer screening etc.
- Decreased ER utilization rate
- Decreased hospitalization
- Decreased per capita health care costs.

Starting Point/Baseline

The baseline for measures is zero

Rationale

The Region 9 Community Assessment (Collins, 2012) identifies the need for "development of lower levels of care in order to prevent the need for high-cost services" in our community. For Dallas County, the presence of a 'co-occurring behavioral health condition is associated with increased case severity of medical encounters and a 36% increase in the average charges per encounter (Collins, 2012). Lack of community based services also results in "significantly overcrowded emergency rooms" for people seeking crisis services. By providing integrated services within Metrocare's community based integrated care clinics, behavioral and physical healthcare staff can assist patients with stabilization of both symptoms of mental illness, as well as prevention or stabilization of physical health illnesses. The result of engagement and treatment in an integrated environment will result in decreased use of higher levels of care, improved patient functioning, improved HEDIS measures for chronic medical illnesses,

improved patient satisfaction outcomes and a decrease in local dollars spent on emergency room visits for patients with comorbid mental and physical illnesses. The integrated medical record, regular team meetings and case conferences, as well as ongoing CQI meetings will assist behavioral health and physical health providers in identifying barriers to engagement and outcome improvements. The North Texas Behavioral Health Authority has identified transportation as one of the major barriers to individuals accessing services (Collins, 2012). The four community mental health clinic sites targeted for integration are all located on Dallas Area Rapid Transit bus routes or rail lines, and are also located on high capacity local streets, easily accessible by major highways.

As per Dallas county community health dash board Parkland Health and Hospital systems:

- 34.1 % of Emergency room visits in Dallas County in 2010 are for non emergent conditions. We are located in Dallas County and by providing open access to primary care services we will be able to decrease the ED visits for non emergent conditions.
- The number of primary care physicians per 100,000 population in Dallas county is 82.3 in 2010 compared to Texas average of 95.2 – Having primary care services in Metrocare will increase the access to preventive care utilization there by decreasing health care costs.
- Dallas county Health outcomes on heart disease death rate, cancer death rate, stroke death rate and COPD death rate were worse than the bench mark when compared to 8 peer counties. . By offering Primary care services in Dallas county locations of Metrocare we will be able to decrease non emergent ED visits, increase preventive care utilizations, improve health outcomes and decrease health care costs

Project Options: Core Components

2.15.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.

Required core components:

a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community.

   -Co-located, closely collaborated behavioral and primary care services will occur in four currently existing Metrocare outpatient clinics by Year 5 of the project. These clinics are proximately located to zip codes which have been identified to have high rates of chronic disease occurrence (Collins, 2012)
   -Clinics are located within Dallas County in Region 9 and serve approximately 17,000 persons per month.

b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.

-Scheduling for behavioral and physical health services currently exist as a part of Metrocare's electronic health record (EHR)
-Metrocare's current EHR has the capacity for development into an integrated behavioral and primary health care record which will allow for information sharing between behavioral health and primary care providers
-Patients will sign a release of information document which allows for information exchange between behavioral and primary care providers

c) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers

-Co-located behavioral and primary care staff, integrated scheduling, and integrated EHR all serve to enhance communication, data-sharing, and referral between behavioral and physical health providers.
-Formal protocols and processes for referral will be completed in year 2

d) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc. to provide services in the specified locations.

-Mental health and chemical dependency specialists are currently co-located within Metrocare clinics and will offer services to patients referred by primary care practitioners
-Physical health staff are being recruited and hired and will operate within the same location as behavioral health and chemical dependency staff. Primary care staff will accept patients referred by behavioral health care staff
-Family Practice Advanced Nurse Practitioners will be cross-trained in diagnosing and treating behavioral health issues

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:

-Daily morning meetings between behavioral and physical healthcare staff for preview of the day's schedule, and brief consultation among team members as clinically indicated
-Case conferences will be scheduled on a weekly basis, but may occur on an as-needed basis whenever the behavioral or physical health teams deem necessary
-Metrocare's HER has the capacity to develop and integrated treatment plan should behavioral health services cease to be a carve-out in the future. However, treatment plans will have input from both behavioral and physical healthcare providers.

f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated Electronic health record system or participation in health information exchange-depending on the size and scope of the local project.

-Metrocare's current EHR has the capacity to collect data in an integrated setting

g) Explore the need for and develop any necessary legal agreement that may be needed in a collaborative practice.

-Patients who are engaged in both behavioral and physical healthcare services will sign a release of information document, allowing for information sharing among behavioral and physical healthcare staff primary care staff

h) Arrange for utilities and building services for these settings.

-Utilities and building services are already in place as a part of Metrocare's routine facility management department, including the handling of bio hazardous materials and routine cleaning and maintenance. These services will be expanded to any areas designated for the provision of physical healthcare

i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services, as well as the healthcare outcomes of individuals treated in these integrated service settings.

-The currently available centralized scheduling system, provides ability to track utilization of integrated services
-Metrocare's integrated EHR will provide the ability to track healthcare outcomes

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 '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.
-Continuous Quality Improvement (CQI) will be undertaken by utilization of the rapid cycle improvement process in one integrated clinic location prior to expansion of the model to multiple other sited
-The integrated healthcare team will examine positive impacts, as well as outcomes which do not meet expectations, with a goal of continuous improvement of outcomes, customer satisfaction and expansion of services

Unique community need identification numbers the project addresses

CN.6: Primary care and behavioral health

How the project is a significant enhancement to an existing delivery system reform initiative

This project will significantly enhance access to primary care services for persons with severe and persistent mental illnesses in Dallas County.

Related Category 3 Outcome Measure(s)

- IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)

Rationale: Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure.

Relationship to Other Projects

This project is one element of the behavioral health services continuum of care and relates to all other projects that provide/enhance services along the continuum:

137252601.1.1	Metrocare—Workforce Enhancement
137252607.2.2	Metrocare –ACT (Assertive WRAP-around Program)
137252607.2.3	Metrocare—Family Preservation
137250607.2.4	Metrocare—Center for Children with Autism
137250607.2.5	Metrocare—Day Program

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

Learning Collaborative—Metrocare plans to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV—Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

By offering easy access preventive services, case management, chronic disease management, health education and care coordination, we will be able to improve the quality of life and life expectancy of our clients. A randomized trial study by Druss et al in 2001 showed that integrated medical care in patients with serious psychiatric illness have increased preventive care utilization and greater improvement in health (Druss, B et al, 2001).
We based our valuation on IMPACT research trails which showed greater quality outcomes and improved health care costs. Lower long term savings on health care costs (4 yr) were up to $3,363 per patient. They had lower health care cost in every category including but not limited to outpatient and inpatient medical and surgical costs, pharmacy costs and other outpatient costs. (Mauer & Jarvis, 2010). Our goal is to serve 4000 clients by year four the cost savings will be 3500x $3,363 = $**11,770,500**.

Endnotes/References

1. *Dallas county Community Health Dashboard Parkland Health and Hospital Systems.* (2011). Retrieved Aug 2012, from Heathyntexas.org: http://www.healthyntexas.org/javascript/htmleditor/uploads/dashboard_2011_final.pdf

2. Druss, B. et al. (2001, Sept). *Integrated medical care for patients with serious psychiatric illness.* Retrieved Aug 2011, from Archives of General Psychiatry : http://archpsyc.jamanetwork.com/article.aspx?articleid=481816

3. Mauer, B., & Jarvis, D. (2010, June 30). *The Business Case for Bidirectional Integrated care*. Retrieved October 2012, from California Mental health services authority: http://ibhp.org/uploads/file/Business_Case_for_Integration_6-10%20Mauer.pdf

4. P arks, J. etal (2006, Oct). *Morbidity and Mortality in People with serious Mental Illness.* Retrieved Aug 2012, from nasmhpd.org: http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortaility%20-%20Final%2011-06.pdf

137252607.2.1	*Project Option: 2.15.1*	*Project Components: A-J*	*Primary Care Integration*
Dallas County MHMR Center dba Metrocare Services			*137252607*
Related Category 3 Outcome Measures:	*137252607.3.2*	*IT-1.7*	*Controlling High Blood Pressure*

Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/2013-9/30/2014)**	**Year 4 10/1/2014-9/30/2015)**	**Year 5 10/1/2015-9/30/2016)**
Process Milestone 1 **P-2**. Identify existing clinics or other community-based settings where integration could be supported **Metric P-2.1:** Identification of 4 Metrocare Community Mental Health Clinics which can support mental health and primary care integration **Goal**: Plan and develop facilities for provision of primary care services at one site **Data Source**: Metrocare facilities department **Milestone 1 Estimated Incentive Payment: $71,852** **Process Milestone 2** **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 providers and vice versa **Metric P-3.1 :** Number and types of referrals that are made between providers at the location **Baseline:** 0	**Process Milestone 6** **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 providers and vice versa **Metric P-3.1 :** Number and types of referrals that are made between providers at the location **Baseline:** Determined by Year 2 data **Goal:** Ongoing tracking of data through Year 3 **Data Source**: Metrocare shared electronic scheduling program and integrated Electronic Health Record (EHR) **Metric P-3.2:** Number of referrals that are made outside of the location **Baseline:** Determined by Year 2 data **Goal:** Continue tracking of data through Year 3. **Data Source:** Metrocare Electronic Health Record; survey data **Metric P-3.3:**	**Process Milestone 9** **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 providers and vice versa **Metric P-3.1 :** Number and types of referrals that are made between providers at the location **Baseline:** Determined by Year 3 data **Goal:** Ongoing tracking of data through Year 3 **Data Source**: Metrocare shared electronic scheduling program and integrated Electronic Health Record (EHR) **Metric P-3.2:** Number of referrals that are made outside of the location **Baseline:** Determined by Year 3 data **Goal:** Continue tracking of data through Year 4. **Data Source:** Metrocare Electronic Health Record; survey data **Metric P-3.3:**	**Process Milestone 12** **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 providers and vice versa **Metric P-3.1 :** Number and types of referrals that are made between providers at the location **Baseline:** Determined by Year 4 data **Goal:** Ongoing tracking of data through Year 5 **Data Source**: Metrocare shared electronic scheduling program and integrated Electronic Health Record (EHR) **Metric P-3.2:** Number of referrals that are made outside of the location **Baseline:** Determined by Year 4 data **Goal:** Continue tracking of data through Year 5 **Data Source:** Metrocare Electronic Health Record; survey data **Metric P-3.3:** Number of referrals which follow the established standards

137252607.2.1	*Project Option: 2.15.1*	*Project Components: A-J*	*Primary Care Integration*
Dallas County MHMR Center dba Metrocare Services			*137252607*
Related Category 3 Outcome Measures:	*137252607.3.2*	*IT-1.7*	*Controlling High Blood Pressure*

Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/2013-9/30/2014)**	**Year 4 10/1/2014-9/30/2015)**	**Year 5 10/1/2015-9/30/2016)**
Goal: Develop a tracking tool and survey for providers to track referrals and reasons for referral, as well as degree and quality of information sharing; review of data and survey results **Data Source**: Metrocare shared electronic scheduling program and integrated Electronic Health Record (EHR) **Metric P-3.2:** Number of referrals that are made outside of the location **Baseline:** 0 **Goal:** Develop a survey for providers to track numbers of patients referred outside of the location and surveys of providers to determine the degree and quality of information sharing; review of the referral data and survey results **Data Source:** Metrocare Electronic Health Record **Metric P-3.3:** Number of referrals which follow the established standards **Baseline:** 0 **Goal**: Standards to be established in Year 2 **Data Source:** Metrocare Electronic Health Record	Number of referrals which follow the established standards **Baseline:** To be determined by Year 2 data **Goal**: Continue data tracking in Year 3 **Data Source:** Metrocare Electronic Health Record; survey data **Milestone 6 Estimated Incentive Payment: $179,018** **Process Milestone 7** **P-5.** Develop integrated sites reflected in the number of locations and providers participating in the Integration project **Metric P-5.1:** One new community based setting where integrated health services are delivered **Baseline:** 1 integrated clinic, serving 500 Metrocare patients **Goal:** 2 integrated healthcare clinics, serving 1500 Metrocare patients with integrated behavioral and physical healthcare **Data source:** Metrocare facilities department **Metric P-5.2:** Number of primary care providers newly located in behavioral health	Number of referrals which follow the established standards **Baseline:** To be determined by Year 3 data **Goal**: Continue data tracking in Year 4 **Data Source:** Metrocare Electronic Health Record; survey data **Milestone 9 Estimated Incentive Payment:$267,503** **Process Milestone 10** **P-5.** Develop integrated sites reflected in the number of locations and providers participating in the Integration project **Metric P-5.1:** One new community based setting where integrated health services are delivered **Baseline:** 2 integrated clinics, serving 1000 Metrocare patients **Goal:** 3 integrated healthcare clinics, serving 2500 Metrocare patients with integrated behavioral and physical healthcare **Data source:** Metrocare facilities department **Metric P-5.2:** Number of primary care providers	**Baseline:** To be determined by Year 4 data **Goal**: Continue data tracking in Year 5 **Data Source:** Metrocare Electronic Health Record; survey data **Milestone 12 Estimated Incentive Payment:$316,434** **Process Milestone 13** **P-5.** Develop integrated sites reflected in the number of locations and providers participating in the Integration project **Metric P-5.1:** One new community based setting where integrated health services are delivered **Baseline:** 3 integrated clinics, serving 1500 Metrocare patients **Goal:** 4 integrated healthcare clinics, serving 3500 Metrocare patients with integrated behavioral and physical healthcare **Data source:** Metrocare facilities department **Metric P-5.2:** Number of primary care providers newly located in behavioral health settings

137252607.2.1	*Project Option: 2.15.1*	*Project Components: A-J*	*Primary Care Integration*
Dallas County MHMR Center dba Metrocare Services			*137252607*
Related Category 3 Outcome Measures:	*137252607.3.2*	*IT-1.7*	*Controlling High Blood Pressure*

Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/2013-9/30/2014)**	**Year 4 10/1/2014-9/30/2015)**	**Year 5 10/1/2015-9/30/2016)**
Milestone 2 Estimated Incentive Payment: $71,852 **<u>Process Milestone 3</u>** **P-4.** Assess ease of access to potential locations for project implementation **<u>Metric P-4.1:</u>** Access to major roadways, bus routes, or proximity to a large number of individuals who may benefit from services **Goal:** Four clinics identified, each of which is located on Dallas Area Rapid Transit (DART) bus and/or rail lines. All clinics are proximate to major freeways with easy clinic access via large, well-traveled internal streets **Data Source:** Metrocare facilities department; DART transportation routes **Milestone 3 Estimated Incentive Payment**: $71,852 **<u>Process Milestone 4</u>** **P-5.** Develop integrated sites reflected in the number of locations and providers participating in the integration project **<u>Metric P-5.1:</u>** Establish one community based setting where integrated health	settings **Baseline:** 3 providers in one location **Goal:** 6 providers in 2 locations **Data Source:** Metrocare Human Resources Department **Metric P-5.3** Not applicable **Milestone 7 Estimated Incentive Payment: $179,018** **<u>Process Milestone 8</u>** **P-6.** Develop integrated behavioral health and primary care services within co-located sites **<u>Metric P- 6.1:</u>** Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system) **Baseline:** 20% **Goal**: 40% of providers will achieve Level 4 of interaction **Data Source:** Metrocare electronic health record; survey data **<u>Metric P-6.2:</u>** Not applicable **Milestone 8 Estimated Incentive Payment: $179,018** **<u>Improvement Milestone 3</u>**	newly located in behavioral health settings **Baseline:** 6 providers in two locations **Goal:** 9 providers in 3 locations **Data Source:** Metrocare Human Resources Department **Metric P-5.3** Not applicable **Milestone 10 Estimated Incentive Payment:$267,503** **<u>Process Milestone 11</u>** **P-6.** Develop integrated behavioral health and primary care services within co-located sites **<u>Metric P- 6.1:</u>** Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system) **Baseline:** 40% **Goal**: 60% of providers will achieve Level 4 of interaction **Data Source:** Metrocare electronic health record; survey data **<u>Metric P-6.2:</u>** Not applicable **Milestone 11 Estimated Incentive**	**Baseline:** 9 providers in three locations **Goal:** 12 providers in 4 locations **Data Source:** Metrocare Human Resources Department **Metric P-5.3** Not applicable **Milestone 13 Estimated Incentive Payment: $316,434** **<u>Process Milestone 14</u>** **P-6.** Develop integrated behavioral health and primary care services within co-located sites **<u>Metric P- 6.1:</u>** Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system) **Baseline:** 60% **Goal**: 80% of providers will achieve Level 4 of interaction **Data Source:** Metrocare electronic health record; survey data **<u>Metric P-6.2:</u>** Not applicable **Milestone 8 Estimated Incentive Payment: $316,434**

137252607.2.1	*Project Option: 2.15.1*	*Project Components: A-J*	*Primary Care Integration*
Dallas County MHMR Center dba Metrocare Services			*137252607*
Related Category 3 Outcome Measures:	*137252607.3.2*	*IT-1.7*	*Controlling High Blood Pressure*

Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/2013-9/30/2014)**	**Year 4 10/1/2014-9/30/2015)**	**Year 5 10/1/2015-9/30/2016)**
services are delivered **Baseline:** 0 **Goal:** Serve 500 patients in integrated behavioral and physical healthcare services **Data source:** Metrocare Clinical System **Metric P-5.2:** Number of primary care providers newly located in behavioral healthcare setting **Baseline:** 0 **Goal:** Hire 3 medical staff for provision of primary care services, including a primary care physician, a family practice Advanced Nurse Practitioner, and an RN **Data Source:** Metrocare Human Resources Department **Metric P-5.3:** Not applicable **Milestone 4 Estimated Incentive Payment: $71,852** **Process Milestone 5** **P-6.** Develop integrated behavioral health and primary care services within co-located sites **Metric P-6.1:** Number of providers achieving Level 4 of interaction (close collaboration in a	**I-10.** No-Show Appointments **Metric I-10.1:** X% decrease the "no shows" for behavioral and physical health appointments **Baseline:** Determined by Year 2 data **Goal:** Decrease "no show" appointments by 5% in Year 3 over Year 2 baseline **Data Source:** Electronic scheduling system; 'no show' reports **Improvement Milestone 3 Estimated Incentive Payment: $179,019** **Improvement Milestone 4** **I-12.** Improved Consumer satisfaction with Integrated Services **Metric I-12.1:** X% of people report satisfaction with integrated services on the CAHPS **Baseline:** 60% of people report satisfaction with integrated services on the CAHPS **Goal:** 70% of people will report satisfaction with integrated services on the CAHPS **Data Source:** Completed survey data from consumer satisfaction	**Payment:$267,503** **Improvement Milestone 5** **I-10.** No-Show Appointments **Metric I-10.1:** X% decrease the "no shows" for behavioral and physical health appointments **Baseline:** Determined by Year 3 data **Goal:** Decrease "no show" appointments by 5% in Year 4 over Year 3 baseline **Data Source:** Electronic scheduling system; 'no show' reports **Improvement Milestone 5 Estimated Incentive Payment: $267,504** **Improvement Milestone 6** **I-12.** Improved Consumer satisfaction with Integrated Services **Metric I-12.1:** X% of people report satisfaction with integrated services on the CAHPS **Baseline:** 70% of people report satisfaction with integrated services on the CAHPS **Goal:** 80% of people will report satisfaction with integrated services	**Improvement Milestone 7** **I-10.** No-Show Appointments **Metric I-10.1:** X% decrease the "no shows" for behavioral and physical health appointments **Baseline:** Determined by Year 4 data **Goal:** Decrease "no show" appointments by 5% in Year 5 over Year 4 baseline **Data Source:** Electronic scheduling system; 'no show' reports **Improvement Milestone 7 Estimated Incentive Payment:$316,434** **Improvement Milestone 8** **I-12.** Improved Consumer satisfaction with Integrated Services **Metric I-12.1:** X% of people report satisfaction with integrated services on the CAHPS **Baseline:** 80% of people report satisfaction with integrated services on the CAHPS **Goal:** 90% of people will report satisfaction with integrated services on the CAHPS **Data Source:** Completed survey data from consumer satisfaction

137252607.2.1	*Project Option: 2.15.1*	*Project Components: A-J*	*Primary Care Integration*
Dallas County MHMR Center dba Metrocare Services			*137252607*
Related Category 3 Outcome Measures:	*137252607.3.2*	*IT-1.7*	*Controlling High Blood Pressure*

Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/2013-9/30/2014)**	**Year 4 10/1/2014-9/30/2015)**	**Year 5 10/1/2015-9/30/2016)**
partially integrated system). **Baseline:** 0 **Goal:** 20% of providers will achieve Level 4 of interaction **Data Source**: Electronic Health Record; survey data; referral tracking tools **Metric P-6.2:** Not applicable **Milestone 5 Estimated Incentive Payment: $71,851** **Improvement Milestone 1** **I-10.** No-Show Appointments **Metric I-10.1:** X% decrease the "no shows" for behavioral and physical health appointments **Baseline:** To be determined at start of services in Year 2 **Goal:** Decrease "no show" appointments by 5% in Year 2 **Data Source:** Electronic scheduling system; 'no show' reports **Improvement Milestone 1 Estimated Incentive Payment: $71,852** **Improvement Milestone 2** **I-12.** Improved Consumer satisfaction with Integrated Services **Metric I-12.1:** X% of people report	surveys (CAHPS) **Improvement Milestone 4 Estimated Incentive Payment: $179,019**	on the CAHPS **Data Source:** Completed survey data from consumer satisfaction surveys (CAHPS) **Improvement Milestone 6 Estimated Incentive Payment: $267,504**	surveys (CAHPS) **Improvement Milestone 8 Estimated Incentive Payment: $316,435**

137252607.2.1	*Project Option: 2.15.1*	*Project Components: A-J*	*Primary Care Integration*	
Dallas County MHMR Center dba Metrocare Services				*137252607*
Related Category 3 Outcome Measures:	*137252607.3.2*	*IT-1.7*	*Controlling High Blood Pressure*	

Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/2013-9/30/2014)**	**Year 4 10/1/2014-9/30/2015)**	**Year 5 10/1/2015-9/30/2016)**
satisfaction with integrated services on the CAHPS **Goal:** 60% of people will report satisfaction with integrated services on the CAHPS **Data Source:** Completed survey data from consumer satisfaction surveys (CAHPS) **Improvement Milestone 2 Estimated Incentive Payment: $71,851**			
Year 2 Estimated Milestone Bundle Amount (add incentive payment amounts from each milestone): $502,963	Year 3 Estimated Milestone Bundle Amount: $895,092	Year 4 Estimated Milestone Bundle Amount: $1,337,517	Year 5 Estimated Milestone Bundle Amount: $1,582,171
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $4,317,743			

Project Option 2.13.1 – Assertive Community Team for Persons with Developmental Disabilities

Unique Project ID: 137252607.2.2
Performing Provider Name/TPI: Dallas County MHMR Center dba Metrocare Services/ 137252607

Provider: Metrocare Services is a behavioral health organization, serving approximately 50,000 persons in Dallas County with mental illness and developmental disabilities.

Interventions: The ACT Team will be on-call to travel to the acute care facility, jail or school to help assess and stabilize consumers and will also provide follow-up services to those clients to ensure the destructive pattern that led to the need for acute services is eliminated or significantly reduced. A licensed therapist will manage the daily operations of this program, with behavior intervention staff carrying small caseloads of no more than 10 consumers. The direct care staff will make multiple home and/or community face-to-face visits each week. ACT clients will receive at minimum, 8 hours of services per month.

Need for the project: The Region 9 Community Assessment identifies that there are insufficient community based programs that provide crisis intervention and stabilization services to effectively and efficiently reduce the utilization of higher levels of care (i.e. ERs, hospitals, jails and detention facilities). Further, the staff members in these facilities are often not trained to successfully assess and provide for the needs of individuals with developmental disabilities. An ACT program for clients with developmental disabilities will allow Metrocare to utilize its specially trained staff to assist in crisis situations at community locations and then provide the ongoing services needed to avoid crisis in the future.

Target population: The target population includes indigent patients or those insured by Medicaid that have a developmental disability and are in need of intensive intervention due to consistent demonstration of alarming behaviors that result in hospitalization or arrest. The project estimates to serve 27 clients in year 3, 41 clients in year 4 and 54 clients in year 5.

Category 1 or 2 expected benefits: The goal of this project is to increase the number of clients served each year (DY 3 27, DY 4 41, DY 5 54) and to decrease patient utilization rates of out-of-home treatment facilities for those served by ACT by 70% in DY 4 and 75% in DY 5.

Category 3 outcomes: The goal for this project is improved Quality of Life: IT-10.1

- DY 4 – 25% of those served will report improved quality of life/functional status. Data source: Achenbach System of Empirically Based Assessment (ASEBA)
- DY 5 – 50% of those served will report improved quality of life/functional status. Data source: Achenbach System of Empirically Based Assessment (ASEBA)

Project Description

Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting.

Currently people with developmental delays and who have behavior issues usually end up in acute care hospitals or jails. We know that professional staff in those facilities are not specifically trained or equipped to successfully assess, and provide for the needs of these individuals. The episodes can be lengthy and the consumers are integrated with the general public often raising risk for themselves and others. At times the consumer is simply medicated and released back to the care of their personal caregiver without proper assessment and/or treatment to help them be successful in the future. This often causes a cycle of readmissions to the emergency room and/or hospital.

The judicial system is even less likely to provide the needed services. Often following arrest, the consumers are released without any follow-up and the pattern is often repeated over and over.

The cost to the community is significant.

To address this, the Behavior Treatment Services Assertive Community Wrap-around Treatment Team (ACT) will be on-call to travel to the acute care facility, jail, or school to help assess and stabilize the situation and then provide follow –up services to ensure the destructive pattern that led to the need for acute services is eliminated or at least significantly reduced. A licensed therapist will manage the day to day operations and behavior intervention staff will carry small caseloads of no more than 10 consumers each. The staff will make multiple home/community face-to-face visits each week.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals

The goal is to decrease potential readmission to psychiatric facilities and incarcerations and to stabilize the individual within the home and community setting and to provide behavioral services to increase individual, family, and community safety and to address needs that will keep the individual in the home and community.

The Region 9 Community Needs Assessment highlights that “an inadequate supply of behavioral health services is one of the most significant unmet health needs” of our community (Collins, RHP 9 Community needs assessment report, 2012). The implementation of an Assertive Community Wrap around Treatment Team (ACT) will address the community needs outlined in this assessment by maintaining individuals in their homes while increasing relevant

and effective services to those individuals and their caregivers. This model will decrease the time and cost associated with multiple hospitalization/emergency department visits, involvement with criminal justice system and institutionalization.

Additionally, this meets the regional goal of coordinated care for persons with behavioral needs.

Challenges

According to the Texas Council for Developmental Disabilities (TCDD), approximately 475,265 people in the state of Texas are diagnosed with a Development Disability. An APA task force estimated that 30-70 % of persons diagnosed with a developmental disability will experience the effects of a mental health condition at some point in their lifetime. Due to the high prevalence rate of persons with developmental disabilities having a co-occurring mental health condition, there is a need in the community for appropriate resources that address both challenges. Furthermore, accessibility to trained staff, crisis intervention, and support services has been found to be a major barrier for this population. Due to the inaccessibility of services for this population, persons with developmental disabilities who have severe behavior issues often end up in Psychiatric Emergency Rooms. Care givers and/or law enforcement bring the consumers to the ER due to the consumer manifesting extreme behaviors that are a danger to the consumer and/or others. Once at the psychiatric emergency room, hospital personnel are not usually specifically trained in how best to work with individuals with disabilities. The situation can be become more intense as the consumer is mixed with the general population. This often leads to instability across multiple consumers. The consumer can be in the emergency room for lengthy periods of time as a solution is sought.

If the care giver calls the local police department, the officers who respond are not trained behavioral clinicians and a situation that could possibly be defused results in an arrest. The person with disabilities, if taken to jail, is housed with the general population without the cognitive capacity or adaptable coping skills to deal with the often hostile environment.

Currently there are no local organizations that provide ACT type services to this specific population. The result, as described above, is a revolving door for these individuals, in and out of the hospital and/or jail, with little intervention done to stop the cycle. Metrocare provides outpatient services to clients with developmental disabilities and mental illness, but cannot, in its current capacity, provide intensive ACT services to client dually diagnosed and frequent users of higher levels of care. The goal of the ACT program would be to provide that immediate stabilization and then transition the client to traditional outpatient services for maintenance.

5-Year Expected Outcome for Provider and Patients

- Recruit and train community health workers to serve in the program.

- Increase number of people with developmental disabilities served by team by 27 over baseline.
- Increase number of people with developmental disabilities served by team by 41 over baseline.
- Increase number of people with developmental disabilities served by team by 54 over baseline.
- Decrease the rate of Emergency Room Visits and readmissions to psychiatric hospitals for those served
- Decrease rate of criminal justice involvement for those served
- Decrease referral to or placement in a state supported living facility

Starting Point/Baseline

Baseline for measures (clients served, number of encounters, and number of trained staff) is zero. Hiring, training of staff and enrollment of the initial 27 clients to be served will occur in DY 3.

Rationale

As described in the Region 9 Community Assessment (Section IV Behavioral Health), there are insufficient community based programs that provide crisis intervention and stabilization services to effectively and efficiently reduce the utilization of higher levels of care (i.e. ERs, hospitals, jails and detention facilities). An ACT program for clients with developmental disabilities will allow Metrocare to utilize its specially trained staff to assist in crisis situations at community locations and then provide the ongoing services needed to avoid crisis in the future. This approach to treatment fosters frequent encounters in the home setting with a focus on building adaptive skills and resolving client needs to ensure stabilization in the home. Core components of the program will include psychiatric evaluation, behavioral assessment, medication management, crisis intervention, counseling and rehabilitative services, and group therapy.

Metrocare Services is the largest provider of mental health services in Dallas County. We serve approximately 1,000 people diagnosed with a developmental disability each month and 10,000 people diagnosed with a mental health disorder. To provide quality services to such a large population, we must implement programs that are proven to be effective with our families. Further, as a member of this community, we recognize the societal and financial impact that multiple psychiatric hospitalizations, CPS and/or juvenile justice involvement, and an

individual's removal from home can have on a family and the greater community. The ACT Program will take a comprehensive, systematic approach to treating individuals with complex needs, providing intensive services to quickly establish stabilization and then work rigorously to assist the individual/caregiver with getting needs met to sustain safety and stabilization. Through the efforts of this program, there will be a decrease in the number of individuals readmitted to psychiatric hospitals, involved in the criminal justice system, or placed in State Supported Living facility.

Project Components

This project has five required project components including:

A. Assess size, characteristics and needs of target population

B. Review literature/experience with populations similar to target population to determine community based interventions that are effective in averting negative outcomes

C. Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes

D. Design models which include appropriate range of community-based services and residential supports

E. Assess the impact of interventions based on standardized quantitative measures and qualitative analysis

Each of these required components are addressed in the Project Proposal by:

A. Conducting Needs Assessment

B. Conducting Needs Assessment and program design of interventions

C. Use of real time data for rapid cycle improvement for Continuous Quality Improvement; use of standardized tools (Metrocare Clinical Data System and the Achenbach) to determine decrease of out-of-home treatment episodes and increase in community-based services and client functioning

D. Conduct Needs Assessment and program design of interventions

E. Use of standardized tools (Metrocare Clinical Data System and the Achenbach) to determine decrease of out-of-home treatment episodes and increase in community-based services and client functioning

The ADEBA Approach: The Achenbach System of Empirically Based Assessment (ASEBA) offers a comprehensive approach to assessing adaptive and maladaptive functioning. Developed through decades of research and practical experience to identify actual patterns of functioning, the ASEBA provides professionals with user-friendly tools. The ASEVA assesses competencies, adaptive functioning, and behavioral, emotional, and social problems from age 1 ½ to over 90. Numerous studies demonstrate significant associations between ASEBA scores and both diagnostic and special education categories. You can relate ASEBA directly to DSM-IV diagnostic categories by using the DSM-oriented scales for scoring ASEBA forms.

The Process Milestones chosen for this project were derived from the RHP Planning Protocol. A customized improvement milestone was created to evaluate the program's success at reducing out-of-home treatment episodes including stays at a psychiatric hospital, criminal justice center or placement in a residential treatment facility. Metrocare chose to customize this improvement milestone because I-1 focuses only on admission/readmission to a criminal justice setting and would not capture the other facilities of focus. Milestone I-5, functional status, was not chosen as an improvement milestone because it would too closely measure a client's quality of life, which is Metrocare's identified Category 3 Improvement Target.

Unique community need identification numbers the project addresses

CN.5 Behavioral health
CN.6 Primary and behavioral care
CN.7 Behavioral health and jail population

How the project represents a significant enhancement to existing delivery system reform initiative

This project will significantly enhance behavioral health services through recruitment of community health workers to serve patients with behavioral needs. Additionally, by reducing the utilization rates of out-of-home treatment facilities, Metrocare will aid our community partners by alleviating the number of consumers seeking services and allowing those providers to focus on those clients in critical need for inpatient services.

Related Category 3 Outcome Measure(s)

IT 10.1 Quality of Life – as measured by the Achenbach System of Empirically Based Assessment (ASEBA)

The goal of the ACT Program is to provide intensive services to those individual diagnosed with a developmental disability that have experienced a psychiatric hospitalization, interaction with the criminal justice system, high rates of emergency department utilization, or are at-risk for placement in a State Supported Living facility. There are long lasting consequences to individuals and the community at large when a client endures multiple hospitalizations or

removal from home. These consequences include separation from family and deterioration of relationships and stigmatization due to involvement with the legal system. Research indicates that adequate outpatient services decrease hospital use for behavioral health issues (SdosReis, et.al, 2008); thus intensive services that are comprehensive, offering multiple services to address the unique needs of the individual must be provided. The services provided through ACT are proven effective at reducing hospitalizations and out-of-home placements while costing considerably less than expensive treatment episodes in the hospital, judicial system or residential treatment. These services will include 24 hour on-call crisis intervention, skills training, counseling, family/caregiver training, psychiatric evaluation and medication management. Implementing this variety and intensity of services allows a holistic approach to treatment; teaching the clients life skills and coping strategies that allows them to remain in their homes; stabilized with an increase quality of life. To evaluate the program's success regarding improving a client's quality of life, the ASEBA will be used to assess progress from admission to discharge.

Relationship to Other Projects

This project is one element of the behavioral health services continuum of care and relates to all other projects that provide/enhance services along the continuum:

137252601.1.1
137252607.2.1
137252607.2.3
137250607.2.4
137250607.2.5

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

NA

Plan for Learning Collaboratives (if applicable)

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV-Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Metrocare Services determined the value of each project by comparing the budgeted cost of the specific project against the cost to the community should the services go unprovided. In

regards to the ACT Project, the significant cost of hospitalization, emergency room visits, detainment and placement in a State Supported Living Facility were used as comparison data against cost for the community-based ACT Project. The starting point/baseline for the program is zero, with a total census of 27 clients served at the end of DY 3. It is estimated that participation in ACT will result in less than 5% returning to the ER or hospital, less than 5% detained in jail and less than 2% placed in a State Support Living Facility. Metrocare projects that 25% of clients who participate in ACT services in DY 4 will report improved quality of life and 50% of those who participate in DY 5 will report improved quality of life.

Endnotes/References

1. Burge, P. (2009). "Assertive Community Treatment Teams and Adults with Intellectual Disabilities." Retrieved July 2012, from Journal on Developmental Disabilities: http://www.oadd.org/docs/Burge_15-3.pdf.
2. *Chapter 3: Emergency Mental Health Services for People with Developmental Disabilities.* Retrieved July 2012, from University of Washing Green Bay: http://www.uwgb.edu/bhtp/tools/DDBestPractices.pdf
3. *Information on Dual Diagnosis.* Retrieved July 2012, from NADD.org: http://thenadd.org/resources/inforamtion-on-dual-diagnosis/
4. *Texas Council for Developmental Disabilities.* Retrieved July 2012, from Texas Council for Developmental Disabilities: http://www.txddc.state.tx.us
5. *Texas Institutions.* Retrieved Aug 2012, from CommunityNowFreedom.org: http://communitynowfreedom.org/Texas_Institutions.php

137252607.2.2	*2.13.1*	*Project Components: A-E*	*Title: Assertive Community Team for Persons with Developmental Disabilities*
Dallas County MHMR Center dba Metrocare Services			*TPI: 137252607*
Related Category 3 Outcome Measures:	*137252607.3.3*	*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 [P-1] Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources. Metric 1.1: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization, criminal justice involvement. Goal: To derive information to guide program development and priorities Data Source: Literature Review, Survey of Stakeholders, Metrocare Clinical System Milestone 1 Estimated Incentive Payment (max amount): $132,120 Milestone 2 (P-2) Design community-based specialized intervention for target population Metric 2.1: Program plans based on evidence/experience and addresses project goals Goal: Establish ACT-DD program Data Source: Metrocare Needs Assessment and ACT-DD Policy and Procedures Milestone 2 Estimated Incentive	Milestone 3 (P-3) Enroll and serve individuals with targeted complex needs Metric3.1: Increase consumers enrolled in program from baseline (0) to 27 Baseline/Goal: Increase consumers served from 0 to 27 Data Source: Metrocare clinical system Milestone 3 Estimated Incentive Payment (max amount): $162,455 Milestone 4 (P-4) Evaluate and continuously improve interventions Metric 4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Use real time data for rapid-cycle improvement to guide continuous quality improvement Data source: Metrocare Quality Management Department Milestone 5 Estimated Incentive Payment (max amount): $162,456	Milestone 5 [P-3] Enroll and serve individuals with targeted complex needs Metric 3.1: Increase consumers enrolled in program to 41 Goal: Increase consumers served to 41 Data Source: Metrocare clinical system Milestone 4 Estimated Incentive Payment (max amount): $110,283 Milestone 6 (P-4) Evaluate and continuously improve interventions Metric 4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Use real time data for rapid-cycle improvement to guide continuous quality improvement Data source: Metrocare Quality Management Department Milestone 5 Estimated Incentive Payment (max amount): 110,283 Improvement Milestone 1 [I-X] Readmission for out-of-home treatment Metric X.1: Decrease patient utilization rates of out-of-home treatment facilities	Milestone 7 [P-3] Enroll and serve individuals with targeted complex needs Metric 3.1: Increase consumers enrolled in to 54 Goal: Increase consumers enrolled in program to 54 Data Source: Metrocare clinical system Milestone 5 Estimated Incentive Payment (max amount): $123,835 Milestone 8 (P-4) Evaluate and continuously improve interventions Metric4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Use real time data for rapid-cycle improvement to guide continuous quality improvement Data source: Metrocare Quality Management Department Milestone 5 Estimated Incentive Payment (max amount): $123,835 Improvement Milestone 2 [I-X] Readmission for out-of-home treatment Metric X.1: Decrease patient utilization

137252607.2.2	*2.13.1*	*Project Components: A-E*	*Title: Assertive Community Team for Persons with Developmental Disabilities*
Dallas County MHMR Center dba Metrocare Services			*TPI: 137252607*
Related Category 3 Outcome Measures:	*137252607.3.3*	*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)
Payment (max amount): $132,120		Baseline/Goal: Decrease out-of-home treatment episodes by 70% for those in service Data Source: Metrocare Clinical System Improvement Milestone 1 Estimated Incentive Payment:$110,282	rates of out-of-home treatment facilities Baseline/Goal: Decrease out-of-home treatment episodes by 75% for those in service Data Source: Metrocare Clinical System Improvement Milestone 1 Estimated Incentive Payment: $123,835
Year 2 Estimated Milestone Bundle Amount: $264,240	**Year 3 Estimated Milestone Bundle Amount:** $324,911	**Year 4 Estimated Milestone Bundle Amount:** $330,848	**Year 5 Estimated Milestone Bundle Amount:** $ 371,505
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):			**$1,291,504**

Project Option 2.13.1 – Family Preservation Program

Unique Project ID: 137252607.2.3
Performing Provider Name/TPI: Dallas County MHMR Center dba Metrocare Services/ 137252607

Provider: Metrocare Services is a behavioral health organization, serving approximately 50,000 persons in Dallas County with mental illness and developmental disabilities.

Interventions: FPP is a short-term, intensive program that provides crisis intervention, medication management, counseling and case management services to children recently released from the psychiatric hospital or those at-risk for out-of-home placement and their families. As part of this intensive model, clients will receive at minimum 8 hours of services per month.

Need for the project: A recent study published by the Journal of the American Academy of Child and Adolescent Psychiatry concluded that "psychiatric rehospitalization of children is common, most likely in the trimester after discharge and is highly related to both child symptoms and family factors measurable at admission" (Blade, J.2003). Further, the Region 9 Community Needs assessment highlights that "an inadequate supply of behavioral health services is one of the most significant unmet health needs" of our community and that "nearly all intensive services, including evidence-based programs, are provided through the Juvenile Justice System" (Collins, 2012). The implementation of a Family Preservation Model would allow Metrocare to provide intensive, community-based services that are proven to reduce costly out-of-home treatment episodes and addresses priority goals identified in the Region 9 community Assessment Report.

Target population: FPP will serve children and adolescents from psychiatric facilities and/or those at-risk for out-of-home placement due to juvenile justice involvement or placement in residential treatment. The program has projected to serve 200 clients in year 3, 240 clients in year 4 and 280 clients in year 5. The target population will be indigent patients or those covered by Medicaid.

Category 1 or 2 expected benefits: The FPP project will increase the number served in the program each year (DY 3 – 200, DY 4 240, DY 5 – 280) and will decrease patient utilization rates of out-of-home treatment facilities for those served in the FPP Program by 70% for DY4 and 75% for DY 5.

Category 3 outcome: The goal of the FPP Project is improved Quality of Life (IT-10.1):

- Dy 4 – 65% of clients surveyed will report improved quality of life from admission to discharge (Data Source – Child and Adolescent Needs and Strengths Assessment and Metrocare Clinical System)

- DY 5 – 75% of clients surveyed will report improved quality of life from admission to discharge (Data Source – Child an d Adolescent Needs and Strengths Assessment and Metrocare Clinical System)

Project Description

Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting

A Family Preservation Program will serve youth discharged from psychiatric facilities and/or those at-risk for out-of-home placement due to juvenile justice involvement or placement in residential treatment. FPP is a short-term, intensive program that provides medication management, counseling and case management services to clients and immediate family. Participates have access to an on-call clinician to address crisis, in attempt to avoid readmission to hospital or police/juvenile justice involvement. A comprehensive assessment is completed during the first stage of enrollment to identify all client and family needs that influence potential future hospitalizations or removal from the home. Children and their families receive face-to-face services two times per week minimum and services are held at home or in the community on day/time convenient to the family. Clients can be enrolled in the FPP program for a maximum of 3 months and upon discharge, will transition to a less intensive form of outpatient services. During the client's enrollment in FPP, they will receive a minimum of 8 hours of service per month.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals

The goal is to decrease potential admission/readmission to out-of-home treatment facilities (i.e. hospital, detention centers, and/or residential treatment); stabilizing the child within the home and community setting by providing medication management, counseling and case management services to increase family safety and aide in addressing familial needs that will keep the child in the home and community.

The Region 9 Community Needs Assessment highlights that "an inadequate supply of behavioral health services is one of the most significant unmet health needs" of our community (Collins, RHP 9 Community needs assessment report, 2012). In addition, "mental health services available to children are limited" and services "oftentimes do not include the family-focused and comprehensive approach needed to adequately address" client issues (Collins, 2012). Further, the Needs Assessment reports that "nearly all intensive services, including evidence-based programs, are provided through the Juvenile Justice System" (Collins, 2012). The implementation of a Family Preservation Program will address the community needs

outlined in this assessment by maintaining youth in their homes while increasing relevant and effective services to those clients and their families. This model will decrease the time and cost associated with multiple hospitalization, involvement with Juvenile Justice and placement outside of the home.

Additionally, this project meets the regional goals of coordinating care for patients with behavioral needs.

Challenges

Comprehensive assessments of children and adolescents reveal that many children who experience multiple psychiatric hospitalizations and are identified as at-risk for readmission and/or permanent placement outside their home have a multitude of individual and family needs affecting the child's ability to be successful. A recent study published by the Journal of the American Academy of Child and Adolescent Psychiatry supports this claim, concluding that "psychiatric rehospitalization of children is common, most likely in the trimester after discharge, and is highly related to both child symptoms and family factors measurable at admission" (Blader, Joseph. 2003). When treatment for these complex families is not comprehensive, children all too often require intensive and expensive interventions such as multiple hospitalizations, and possible involvement in the judicial or foster care system for long durations of time.

To assist these children and their families, a community provider must have an intensive and comprehensive program that can quickly establish stabilization, boundaries for safety and immediately begin addressing the multitude of needs. Furthermore, this program must provide 24-hr intervention; responding to crisis situations in attempt to avoid further hospitalizations and separation from family members. Currently, Metrocare Services does not have a community-based program that can offer this intensity of intervention. The implementation of a Family Preservation Model would allow Metrocare to provide intensive, community-based services that are proven to reduce costly out-of-home treatment episodes and addresses priority goals identified in the Region 9 Community Assessment Report.

5-Year Expected Outcome for Provider and Patients

- Baseline is Zero
- Increase client enrollment in program by 200 over baseline
- Increase client enrollment in program by 240 of over baseline
- Increase client enrollment in program by 280 of over baseline
- Decrease rate of readmission to psychiatric hospitals for those served

- Decrease rate of Juvenile Justice involvement for those served
- Decrease rate of out-of-home placement for those served

Starting Point/Baseline

Baseline for measures (clients served, number of encounters, and number of trained staff) is zero. Currently Metrocare does not offer any services through a Family Preservation Model.

Rationale

As described in the Region 9 Community Assessment (Section IV Behavioral Health), there are insufficient community based programs that provide crisis intervention and stabilization services to effectively and efficiently reduce the utilization of higher levels of care (i.e. ERs, hospitals, jails and detention facilities). Children and adolescents identified as having multiple needs and barriers are often readmitted to psychiatric facilities following stressful, chaotic and overwhelming triggers. Research shows that these children come from families that compartmentalize their multitude of problems and do not understand the connectedness and how these problems affect a child's ability to cope with stressors and remain safe in the home (Meezan, McCroskey, 1997). The consequence of multiple hospitalizations for this population is expensive treatment that is not determined to be effective. Family Preservation provides intensive, community-based services immediately following a hospital discharge; with the goal of establishing stability, safety and needs resolution to allow the child to avoid hospitalizations and remain in the home.

The Family Preservation Program would also serve those children and adolescent identified as "at-risk" for removal from the home due to chronic behavioral and/or familial issues that may result in out-of-home placement. Youth identified as "at-risk" by their current treatment provider (or relevant community stakeholder such as the school) would refer the child to Metrocare for a comprehensive assessment to determine appropriateness for services. Those youth determined to be in need of a multitude of services and at risk for out-of-home placement will be admitted into the Family Preservation Program.

Metrocare Services is the largest provider of mental health services in Dallas County. We serve approximately 10,000 people diagnosed with a mental illness each month. To provide quality services to such a large population, we must implement programs that are proven to be effective with our families. Further, as a member of this community, we recognize the societal and financial impact that multiple psychiatric hospitalizations, CPS and/or juvenile justice involvement, and child removal from home can have on a family and the greater community. FPP takes a comprehensive, systematic approach to treating families with complex needs, providing community based, intensive services to quickly establish stabilization and then work rigorously to assist the family with getting needs met to sustain safety and stabilization.

Through the efforts of this program, there will be a decrease in the number of children and adolescents readmitted to psychiatric hospitals, placed in Residential Treatment or involved in the juvenile justice system.

Project Components

This project has five required project components including:

A. Assess size, characteristics and needs of target population

B. Review literature/experience with populations similar to target population to determine community based interventions that are effective in averting negative outcomes

C. Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes

D. Design models which include appropriate range of community-based services and residential supports

E. Assess the impact of interventions based on standardized quantitative measures and qualitative analysis

Each of these required components are addressed in the Project Proposal by:

A. Conducting Needs Assessment

B. Conducting Needs Assessment and program design of interventions

C. Use of real time data for rapid cycle improvement for continuous Quality Improvement; use of standardized tools (Metrocare Clinical Data System and CANS) to determine decrease of out-of-home treatment episodes and increase in community-based services and client functioning/quality of life

D. Conduct Needs Assessment and program design of interventions

E. Use of standardized tools (Metrocare Clinical Data System and CANS) to determine decrease of out-of-home treatment episodes and increase in community-based services and client functioning/quality of life

The Child and Adolescent Needs and Strengths (CANS) Comprehensive is an information integration tool designed to support individual case planning, and the planning and evaluation of service systems. The CANS Comprehensive version for Texas is used in service delivery systems that address the mental health of children, adolescents and their families.

The Process Milestones chosen for this project were derived from the RHP Planning Protocol. A customized improvement milestone was created to evaluate the program's success at reducing out-of-home treatment episodes including stays at a psychiatric hospital, juvenile detention center or placement in a residential treatment facility. Metrocare chose to customize this improvement milestone because I-1 focuses only on admission/readmission to a criminal justice setting and would not capture the other facilities of focus. Milestone I-5, functional status, was not chosen as an improvement milestone because it would too closely measure a client's quality of life, which is Metrocare's identified Category 3 Improvement Target.

Unique community need identification numbers the project addresses

CN.5 Behavioral health
CN.6 Primary and behavioral care
CN.7 Behavioral health and jail population

How the project represents a significant enhancement to an existing delivery system reform initiative

This project will significantly enhance behavioral health services through recruitment of community health workers to serve patients with behavioral needs. Additionally, by reducing the utilization rates of out-of-home treatment facilities, Metrocare will aid our community partners by alleviating the number of youth seeking services and allowing those providers to focus on those clients in critical need for inpatient services.

Related Category 3 Outcome Measure(s)

IT-10.1 Quality of Life – as measured by the Child and Adolescent Needs and Strengths Assessment (CANS)

The goal of the Family Preservation Program is to provide intensive community based services to those youth who have experienced a psychiatric hospitalization or are at-risk for removal from home due to juvenile justice involvement or placement in a residential setting. Research indicates that adequate outpatient services decrease hospital use for behavioral health issues (SdosReis, et.al, 2008); however many children who experience multiple hospitalizations and those identified as at-risk for removal from home have a multitude of individual and family needs that negatively affect a child's quality of life and must be addressed for the child to stabilize in the community. Thus, intensive services that are comprehensive, offering multiple services to address unique needs of the family must be provided. The array of services provided through a Family Preservation Model are proven effective at reducing hospitalizations and out-of-home placements while costing considerably less than expensive treatment episodes in the hospital, juvenile justice system or residential treatment. These services will

include case management, skills training, counseling, psychiatric evaluation and medication management. Implementing this variety and intensity of services allows a holistic approach to treatment; examining all domains of a youth's life and can result in an improved quality of life. To evaluate the program's success regarding improving a child's quality of life, the Child and Adolescent Needs and Strengths Assessment will be used at admission and discharge.

Relationship to Other Projects

This project is one element of the behavioral health services continuum of care and relates to all other projects that provide/enhance services along the continuum:

137252601.1.1
137252607.2.1
137252607.2.2
137250607.2.4
137250607.2.5

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

NA

Plan for Learning Collaboratives (if applicable)

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV-Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Metrocare Services determined the value of each project by comparing the budgeted cost of the specific project against the cost to the community should the services go unprovided. In regards to the FPP Project, the significant cost of hospitalization, emergency room visits, detainment in a juvenile facility and placement in a Residential Treatment Center were used as comparison data against cost for the community-based FPP Project. The starting point/baseline for the program is zero, with a total census of 200 youth served at the end of year three. The total census of those served will increase each year by 40 children. It is estimated that participation in FPP will result in less than 10% returning to the ER or hospital, less than 5% involved in the juvenile justice system and less than 2% placed in a Residential Treatment Center.

Endnotes/References

1. Blader, Joseph. (2003) "Symptom, Family, and Service Predictors of Children's Psychiatric Rehopsitalization within One Year of Discharge." Journal of American Academy of Child and Adolescent Psychiatry.
2. McCroskey, J & Meezan, W. (1997). Family Preservation and Family Functioning.
3. *Behavioral and Developmental Disorders, Parkland Health and Hospital System.* Retrieved Aug 2012, from TXpricepoint.org: http://txpricepoint.org/Report.aspx?DRG=884&FacilityID=1130950
4. *Saving Minds, Saving Money Mental Health Funding.* Retrieved Aug 2012 from The Mental Health America of Texas: http://mhatexas.org
5. *S. dosReis, E Johnson, D Steinwachs, C Rohd, EA Skinner, M Fahey, AF Lehman; Antipsychotic treatment patterns and hospitalizations among adults with schizophrenia. Schizphrenia Research, 2008, Volume 101, Issue 1, pages 304-311*
6. *Monthly Data Review.* Retrieved from The Dallas County Juvenile Department. August 2012
7. Collins, S. (2012). Regional healthcare Partnership 9: Community Needs Assessment Report.

137252607.2.3	*2.13.1*	*Project Components: NA*	*Title:* ***Family Preservation Program***
Dallas County MHMR Center dba Metrocare Services			*TPI: 137252607*
Related Category 3 Outcome Measures :	*~~137252607.3.5~~* *~~137252607.3.6~~* *137252607.3.5*	*~~IT 2.13~~* *~~IT 9.4~~* *IT-10.1*	*~~Other Outcome Improvement Target for Potentially Preventable Admissions~~* *~~Other Outcome Improvement Target for Right Care, Right Setting~~* *Quality of Life*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1] Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources. Metric 1.1: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization, juvenile justice involvement. Goal: To derive information to guide program development and priorities Data Source: Literature Review, Survey of Stakeholders, Metrocare Clinical System Milestone 1 Estimated Incentive Payment (max amount): $305,651 Milestone 2 (P-2) Design community-based specialized intervention for target population Metric 2.1: Program plans based on evidence/experience and addresses project goals Goal: Establish FPP program	Milestone 3 (P-3) Enroll and serve individuals with targeted complex needs Metric3.1: Increase consumers enrolled in program from baseline (0) to 200 Baseline/Goal: Increase consumers served from 0 to 200 Data Source: Metrocare clinical system Milestone 3 Estimated Incentive Payment (max amount): $321,437 Milestone 4 (P-4) Evaluate and continuously improve interventions Metric 4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Use real time data for rapid-cycle improvement to guide continuous quality improvement Data source: Metrocare Quality Management Department Milestone 5 Estimated Incentive Payment (max amount): $321,437	Milestone 5 [P-3] Enroll and serve individuals with targeted complex needs Metric 3.1: Increase consumers enrolled in program from 200 to 240 Goal: Increase consumers served from 200-240 Data Source: Metrocare clinical system Milestone 4 Estimated Incentive Payment (max amount): $242,295 Milestone 6 (P-4) Evaluate and continuously improve interventions Metric 4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Use real time data for rapid-cycle improvement to guide continuous quality improvement Data source: Metrocare Quality Management Department Milestone 5 Estimated Incentive Payment (max amount): $242,295 Improvement Milestone 1 [I-X]	Milestone 7 [P-3] Enroll and serve individuals with targeted complex needs Metric 3.1: Increase consumers enrolled in program from 240 to 280 Goal: Increase consumers enrolled in program from 240 to 280 Data Source: Metrocare clinical system Milestone 5 Estimated Incentive Payment (max amount): $240,332 Milestone 8 (P-4) Evaluate and continuously improve interventions Metric4.1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: Use real time data for rapid-cycle improvement to guide continuous quality improvement Data source: Metrocare Quality Management Department Milestone 5 Estimated Incentive Payment (max amount): $240,332

137252607.2.3	*2.13.1*	*Project Components: NA*	*Title:* ***Family Preservation Program***
Dallas County MHMR Center dba Metrocare Services			*TPI: 137252607*
Related Category 3 Outcome Measures :	~~*137252607.3.5*~~ ~~*137252607.3.6*~~ *137252607.3.5*	~~*IT 2.13*~~ ~~*IT 9.4*~~ *IT-10.1*	~~*Other Outcome Improvement Target for Potentially Preventable Admissions*~~ ~~*Other Outcome Improvement Target for Right Care, Right Setting*~~ *Quality of Life*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Data Source: Metrocare Needs Assessment and FPP Policy and Procedures Milestone 2 Estimated Incentive Payment (max amount): $305,651		Admission/Readmission for out-of-home treatment Metric X.1: Decrease patient utilization rates of out-of-home treatment facilities Baseline/Goal: Decrease out-of-home treatment episodes by 70% for those in service Data Source: Metrocare Clinical System Improvement Milestone 1 Estimated Incentive Payment: $242,294	Improvement Milestone 2 [I-X] Admission/Readmission for out-of-home treatment Metric X.1: Decrease patient utilization rates of out-of-home treatment facilities Baseline/Goal: Decrease out-of-home treatment episodes by 75% for those in service Data Source: Metrocare Clinical System Improvement Milestone 1 Estimated Incentive Payment: $240,332
Year 2 Estimated Milestone Bundle Amount: $611,302	**Year 3 Estimated Milestone Bundle Amount**: $642,874	**Year 4 Estimated Milestone Bundle Amount:** $726,884	**Year 5 Estimated Milestone Bundle Amount:** $720,996
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):			**$2,702,056**

Project Option 2.13.1 – Intensive Applied Behavior Analysis Program (Center for Children with Autism)

Unique Project ID: 137252607.2.4
Performing Provider Name/TPI: Dallas County MHMR Center dba Metrocare Services/ 137252607

Provider: Metrocare Services is a behavioral health organization, serving approximately 50,000 persons in Dallas County with mental illness and developmental disabilities.

Interventions: CCAM will provide an applied behavior analysis based program to children on the autism spectrum and/or children with other developmental disabilities. The program will structured as a tiered system; offering 1:1 staff/ client ratio for Level 1, 1:2 staff/ client ratio for Level 2 and group participation for Level 3.

Need for the project: The CDC reports that 1 in 88 children are diagnosed with an Autistic Spectrum Disorder. Additionally, the report indicated that the rate of autism increases 10-17% annually. Research studies have shown that children diagnosed with autism have the most likelihood of having successful outcomes when they receive early intensive behavioral intervention services. The Region 9 Community Needs Assessment highlights that "an inadequate supply of behavioral health services is one of the most significant unmet health needs" of our community. The implementation of an ABA based program will address the community needs outlined in our region's assessment by maintaining individuals in their homes while increasing relevant and effective services to those individuals and their caregivers. This model will decrease the time and cost associated with Special Education services, multiple emergency department visits and institutionalization.

Target population: CCAM will provide ABA based services to children on the autism spectrum and/or children with other developmental disabilities. The project estimates to serve 46 children in year 2, 64 children in year 3, 82 children in year 4, and 94 children in year 5. The target population will include, but is not solely, indigent clients and children insured by Medicaid. When applicable, CCAM will serve children insured by commercial insurance.

Category 1 or 2 expected benefits: The CCAM project will increase the number served in the program each year and increase the percentage of those served reporting improvement from enrollment to annual functional assessment utilizing the ABLLS standardized assessment.

Category 3 outcomes: The goal of CCAM is to:

- Reduce intensive school services and out-of-home treatment episodes
- Increase patient satisfaction scores related to timely care, appointments and information

Project Description

Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.)

Scientific studies have shown that children diagnosed with autism have the most likelihood of having successful outcomes when they receive early intensive behavioral intervention services. These services should address learning, communication and social skills. Applied Behavior Analysis (ABA) arranges the environment to make behaviors more or less likely to occur in a socially significant setting. While there are many different types of ABA the basics and the way skills are taught are the same. ABA focuses on increasing behaviors, such as communication and social skills in order to decrease inappropriate behaviors. Currently, Applied Behavior Analysis is the most evidence-based treatment available for children with autism.

The Center for Children with Autism at Metrocare (CCAM) will offer quality Applied Behavior Analysis (ABA) services. The goal is to lead each child to his or her potential through evidence based therapy founded on the principles of ABA. The CCAM provides a hands-on approach with assessments, one-to-one therapy, and parent training to maximize progress.

CCAM will provide applied behavior analysis (ABA) to children on the autism spectrum and/or children with other developmental disabilities. The primary focus areas of the CCAM are communication, behavior management, and social skills. ABA techniques are utilized to teach new appropriate skills, such as communication, as well as, decrease inappropriate skills such as aggressive behavior. Each child's program is individualized to their needs, parent receive monthly parent training, and the program is supervised by licensed professionals, including a Board Certified Behavior Analyst. The program is based on a tiered system with levels from 1-3. Level one will be the most intensive and designated for those that are assessed to be the most severe. Level one offers 1:1 staff/client ratio, allowing the staff to give focused attention to the one child and provide immediate teaching and feedback. Children will progress to Level 2, where the ratio is 1:2 staff/client and allows the child to practice those skills learned thus far. Finally, the client will progress to Level 3, which is a group session offered 1 x week, allowing multiple children to interact with one another and refine the skills learned in the program. All therapy will be provided in a fun, creative and energetic environment to maximize a child's potential. The therapy center will be equipped with toys and therapeutic tools designed to help children on the autism spectrum learn.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals

To lead each child to his or her potential through evidence based therapy founded on the principles of ABA. To provide behavioral services to increase self-reliance and improved functioning, thus decrease the need for costly and intensive special education services.

The Region 9 Community Needs Assessment highlights that "an inadequate supply of behavioral health services is one of the most significant unmet health needs" of our community (Collins, RHP 9 Community needs assessment report, 2012). In addition, "mental health services available to children are limited" and services "oftentimes do not include the family-focused and comprehensive approach needed to adequately address" client issues (Collins, 2012). The implementation of an Intensive Applied Behavior Analysis Program will address the community needs outlined in this assessment by maintaining individuals in their homes while increasing relevant and effective services to those individuals and their caregivers. This model will decrease the time and cost associated with Special Education services, multiple emergency department visits, and institutionalization.

Additionally, this project meets the regional goals of coordinating care for patients with behavioral needs

Challenges

Recent reports from the CDC suggest that 1 in 88 children are diagnosed with an Autistic Spectrum Disorder. Texas Council on Autism reported in its 2011 Annual Report that 1.5 million individuals in the United States were affected by Autism. Additionally the report indicated that the rate of autism increases 10-17% annually. The organization, Autism Speaks, estimates that autism costs society $137 billion per year. Autism is a pervasive developmental disorder (PDD) that involves severe deficits in a person's ability to communicate and interact with others. Children with autism often have trouble using their imagination, have a limited range of interests, and may show repetitive patterns of behavior or body movements. The disorder is often associated with some degree of mental retardation. Autism is the most prevalent PDD and the most common of all serious childhood disorders. Autism is four times more common in boys than in girls (1 in 54 boys are affected by Autism). More children will be diagnosed with autism this year than with AIDS, diabetes & cancer combined. There is currently no medical detection or cure for autism and the funding for research is limited when compared to other less prevalent childhood diseases.

5-Year Expected Outcome for Provider and Patients

- Recruit and train community health workers to serve in the program.

- Identify 46 at-risk children with developmental disabilities to enroll.
- Increase number of children with developmental disabilities served by team by 64 over baseline.
- Increase number of children with developmental disabilities served by team by 82 over baseline.
- Increase number of children with developmental disabilities served by team by 94 over baseline.

Starting Point/Baseline

Baseline for measures (clients served, number of encounters, and number of trained staff) is zero.

Rationale

Children diagnosed with an Autism Spectrum Disorder have multiple needs and face multiple barriers. Research shows that these children often benefit from and have the best future outcomes when they receive intensive ABA training. There are limited intensive services available in Region 9 for people with developmental disabilities displaying extreme behaviors. Metrocare offers a graduated system of care for people with developmental disabilities and behavioral health issues. This project completes the continuum of care where gaps currently exist.

Metrocare Services is the largest provider of mental health services in Dallas County. We serve approximately 1,000 people diagnosed with a developmental disability each month and 10,000 people diagnosed with a mental health disorder. To provide quality services to such a large population, we must implement programs that are proven to be effective with our families. Further, as a member of this community, we recognize the societal and financial impact that multiple psychiatric hospitalizations, CPS and/or juvenile justice involvement, and an individual's removal from home can have on a family and the greater community. The Intensive Applied Behavior Analysis Program will take a comprehensive, systematic approach to treating children with complex needs, providing intensive services to quickly establish a plan of care and then work rigorously to assist the individual/caregiver with getting needs met to daily functioning and improve quality of life. Through the efforts of this program, there will be a reduction in the need for costly and intensive Special Education services, and a future reduction in unnecessary Emergency Department visits or placement in a State Supported Living facility.

Project Components

This project has five required project components including:

A. Assess size, characteristics and needs of target population

B. Review literature/experience with populations similar to target population to determine community based interventions that are effective in averting negative outcomes

C. Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes

D. Design models which include appropriate range of community-based services and residential supports

E. Assess the impact of interventions based on standardized quantitative measures and qualitative analysis

Each of these required components are addressed in the Project Proposal by:

A. Program Design, as outlined in Manual of Operations, will include information regarding target population based on evidence and experience.

B. Program Design, as outlined in Manual of Operations, will be based on information derived from literature review and agency experiences with target population, to determine effective and relevant interventions and services to offer.

C. Use of real time data for rapid cycle improvement for continuous Quality Improvement; use of standardized tools (Metrocare Clinical Data System and the ABLLS) to determine decrease of out-of-home treatment episodes and increase in community-based services and client functioning

D. Program Design, as outlined in Manual of Operations, will be based on information derived from literature review and agency experiences with target population, to determine effective and relevant interventions and services to offer.

E. Use of standardized tools (Metrocare Clinical Data System and the ABLLS) to determine decrease of out-of-home treatment episodes and increase in client functioning

The Assessment of Basic Language and Learning Skills - Revised (ABLLS®-R)

Developed by Dr. Partington, the ABLLS®-R system is an assessment tool, curriculum guide, and skills-tracking system used to help guide the instruction of language and critical learner skills for children with autism or other developmental disabilities. This practical and parent-friendly tool

can be used to facilitate the identification of skills needed by your child to effectively communicate and learn from everyday experiences.

Unique community need identification numbers the project addresses

CN.5: Behavioral Health
CN.6: Behavioral Health and Primary Care

How the project represents a significant enhancement to an existing delivery system reform initiative

This project will significantly enhance services for children with autism through teaching children new appropriate skills, such as communication, as well as, decrease inappropriate skills such as aggressive behavior. Each child's program is individualized to their needs, parent receive monthly parent training, and program are supervised by licensed professionals including a Board Certified Behavior Analyst. Therapy is provided in a fun, creative and energetic environment to maximize a child's potential.

Related Category 3 Outcome Measure(s)

IT-9.4: Other outcome target – Right Care, Right Setting -number of home-based clinical interventions over prior years

IT 6.1 Patient Satisfaction – timely care, appointments and information; prescriber communication with patients

The Category 3 Improvement Target regarding providing the right care in the right setting (9.4) and patient satisfaction (6.1) are the related outcomes to this project. Regarding providing the right care in the right setting, we project a decrease of intensive school services and out-of-home treatment episodes by 80% for those in service (Source: Metrocare clinical system). The goal of the Intensive Applied Behavior Analysis Program is to provide intensive services to children diagnosed with a developmental disability who have high levels of problems with communication, social skills, and behavior. These children are at risk for future high levels of costly and intensive special education services, utilization of emergency departments, and placement in residential facilities. Individuals diagnosed with a developmental disability can be a high cost to society and require intensive, specialized supports to prevent costly school services and institutionalization. There are long lasting consequences to this population if they do receive these specialized supports in order function on a daily basis. These consequences include inability to complete daily activities of living, inability to related to other socially, risk for physical/ emotional/ sexual abuse, deterioration of relationships with primary caregivers; and societal stigmatization due developmental disability. By evaluating patient satisfaction with services, Metrocare will assess progress towards the primary goal of this project which is to

expand access to behavioral health services to underserved areas in Dallas County. Further, the quality of patient/clinician communication, as perceived by the client, has been identified as a primary domain for determining satisfaction with services. Metrocare plans to use the Consumer Assessment of Healthcare Providers Survey (CAHPS) to measure patient satisfaction outcomes. Utilizing CAHPS will allow Metrocare to produce comparable data regarding the patient's perspective on care for the selected measures including timely care, appointments, information and prescriber communication with patients.

There is significant financial impact to the community and these improved outcomes are identified as priorities to our region. It is estimated that individuals with a diagnosis of Autism can cost society $137 billion dollars per year. Additionally, research shows that these children often benefit from and have the best future outcomes when they receive intensive ABA training. Thus, intensive services that are comprehensive, offering multiple services to address unique needs of the individual/caregiver must be provided. The services provided through an Intensive Applied Behavior Analysis Program are proven effective at improving daily functioning, communication skills, social skills, and reducing problematic behaviors. These services will include comprehensive functional assessment, skills training, family/caregiver training, and if needed psychiatric evaluation and medication management.

Relationship to Other Projects

This project is one element of the behavioral health services continuum of care and relates to all other projects that provide/enhance services along the continuum:

137252601.1.1
137252607.2.1
137252607.2.2
137250607.2.3
137250607.2.5

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

NA

Plan for Learning Collaboratives (if applicable)

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV-Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Metrocare Services determined the value of each project by comparing the budgeted cost of the specific project against the cost to the community should the services go unprovided. In regards to the Intensive Applied Behavior Analysis program, the significant cost of Special Education services, emergency room visits, and placement in a State Supported Living Facility were used as comparison data against cost for the Intensive Applied Behavior Analysis program. The starting point/baseline for the program is zero, with a total census of 46 at the end of the year two. It is estimated that participation in CCAM will result in less than 10% requiring a high level of support through Special Education services and less than 2% requiring placement in a State Support Living Facility in the future.

Endnotes/References

1. Chasson, G. S.; Harris, G. E.; Neely, W.J. (2007). "Cost Comparison of Early Intensive Behavioral Intervention and Special Education for Children with Autism." Retrieved Aug 2012, from Journal of Child and Family Studies
2. Eldevik, S. et al. (2010). "Using Participant Data to Extend the Evidence Base for Intensive Behavioral Intervention for Children with Autism." Retrieved Aug 2012, from American Association on Intellectual and Developmental Disabilities.
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4. *Facts about Autism.* (2012). Retrieved Aug 2012, from AutismSpeaks.org: http://www.autismspeaks.org//print/node/195
5. *New Data on Autism Spectrum Disorders.* (2012). Retrieved Aug 2012, from CDC.gov: http://www.cdc.gov/Features/CountingAutism/

137252607.2.4	2.13.1	Project Components: A-E	Title: Intensive Applied Behavior Analysis Program
Dallas County MHMR Center dba Metrocare Services			*137252607*
Related Category 3 Outcome Measures :	137252607.3.7 137252607.3.8	IT-9.4 IT-6.1	Other Outcome Improvement Target for Right Care, Right Setting Percent improvement over baseline – 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-2] Design community-based specialized applied behavioral analysis (ABA) based interventions for children with developmental disabilities. Metric 2.1: Program plans based on evidence/experience and addresses project goals Goal: Establish ABA Program Data Source: ABA Program Manual of Operations Milestone 1 Estimated Incentive Payment (max amount): $273,171 **Milestone 2** [P-3] Enroll and serve individuals in need of ABA based services. Metric 3.1: Serve 46 at-risk children with developmental disabilities. Goal: Identify and serve 46 at-risk children with developmental disabilities Data Source: Metrocare clinical system Milestone 2 Estimated Incentive Payment (max amount): $273,170	**Milestone 3** [P-3] Enroll and serve individuals in need of ABA based services. Metric 3.1: Serve 64 at-risk children with developmental disabilities. Baseline/Goal: Increase number of children served from 46 to 64. Data Source: Metrocare clinical system Milestone 3 Estimated Incentive Payment (max amount): $655,717	**Milestone 4** [P-3] Enroll and serve individuals in need of ABA based services. Metric 3.1: Serve 82 at-risk children with developmental disabilities. Baseline/Goal: Increase number of children served from 64 to 82. Data Source: Metrocare clinical system Milestone 3 Estimated Incentive Payment (max amount): $409,876 **Improvement Milestone** 1 I-5: Functional Status Metric 5.1: improved functional status Goal: 25% increase of individuals receiving services will demonstrate improvement from baseline to annual functional assessment utilizing the ABLLS standardized assessment. Data Source: ABLLS, Metrocare Clinical System Milestone 5 Estimated Incentive Payment: $409,877	**Milestone 5** [P-3] Enroll and serve individuals in need of ABA based services. Metric 3.1: Serve 94at-risk children with developmental disabilities. Baseline/Goal: Increase number of children served from 82to 94. Data Source: Metrocare clinical system Milestone 5 Estimated Incentive Payment (max amount): $408,394 **Improvement Milestone 2** I-5: Functional Status Metric5.1: Improved functional status Goal: 50% increase of individuals receiving services will demonstrate improvement from baseline to annual functional assessment utilizing the ABLLS standardized assessment. Data Source: ABLLS, Metrocare Clinical System Milestone 6 Estimated Incentive Payment: $408,395

137252607.2.4	2.13.1	Project Components: A-E	Title: Intensive Applied Behavior Analysis Program	
Dallas County MHMR Center dba Metrocare Services				*137252607*
Related Category 3 Outcome Measures :	137252607.3.7 137252607.3.8	IT-9.4 IT-6.1	Other Outcome Improvement Target for Right Care, Right Setting Percent improvement over baseline – patient satisfaction scores	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $546,341	**Year 3 Estimated Milestone Bundle Amount:** $655,717	**Year 4 Estimated Milestone Bundle Amount:** $819,753	**Year 5 Estimated Milestone Bundle Amount:** $816,789
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):			**$2,838,600**

Project Option 2.13.1 – Site Based Behavioral Day Program for Personal with Developmental Disabilities (Day Program)

Unique Project ID: 137252607.2.5
Performing Provider Name/TPI: Dallas County MHMR Center dba Metrocare Services/ 137252607

Provider: Metrocare Services is a behavioral health organization, serving approximately 50,000 persons in Dallas County with mental illness and developmental disabilities.

Interventions: The Behavioral Day Program will provide short-term behavior intervention and urgent safety net services for individuals with intellectual/developmental disabilities and mental health issues. The individuals will receive crisis diversion services and an intensive package of behavioral services to help stabilize them within their natural environment or if needed within a Respite Facility. While enrolled in the Behavioral Day Program, clients will receive three hours of treatment services per day, five times per week, resulting in 15 hours of services per week.

Need for the project: As described in the Region 9 Community Assessment, there are insufficient community based programs that provide crisis intervention and stabilization services to effectively and efficiently reduce the utilization of higher levels of care. The implementation of a site-based behavioral day program will address the community needs outline in the Region 9 Assessment by maintaining individuals in their homes while increasing relevant and effective services to those individuals and their caregivers. The model will decrease the time and cost associated with multiple hospitalization/emergency department visits, involvement with criminal justice system and institutionalization.

Target population: The target population includes indigent and Medicaid patients who are diagnosed with both a developmental disability and mental health disorder and who consistently demonstrate alarming behaviors that may result in hospitalization, arrest or placement in a residential facility. The program projects to serve up to 16 people in year 2, 24 people in year 3, 32 people in year 4 and 40 individuals in year 5.

Category 1 or 2 expected benefits: This project will increase the number of individuals served in the program each year (DY 2 – 15, DY 3 24, DY 4 -32, DY 5-40). This project will decrease patient utilization rates of out-of-home treatment facilities for those served in the BDP Program by 70% for DY 4 and 80% for DY 5.

Category 3 outcomes: The goal for this project is: improved Quality of Life IT-10.1

- DY 4 – 25% of those served will report improved quality of life/functional status. Data source: Archenbach System of Empirically Based Assessment (ASEBA)

- DY 5 - 50% of those served will report improved quality of life/functional status. Data source: Archenbach system of Empirically Based Assessment (ASEBA)

Project Description

Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.)

Individuals with dual diagnoses (developmental disability and mental health issues) often require specialized support to prevent institutionalization and/or incarceration. The Behavioral Day Program (BDP) can provide short-term behavior intervention and urgent safety net services for individuals with intellectual and developmental disabilities. The program is designed to protect individuals from deteriorating mental health, injurious behaviors, incarceration, and institutionalization. The individual will receive crisis diversion services and an intensive package of behavioral services to help stabilize them within their natural environment or if needed within a Respite facility.

Individuals in the BDP program will be provided with a comprehensive support team that will help develop an intense individualized behavior treatment plan for the individual. This team includes the individual, LAR/guardian, Licensed Psychologist, Behavior Intervention Specialists, and MRA/Provider representative. Services will include implementation of the individualized behavior treatment plan, intensive parent/staff training, and transition to least restrictive long-term residential and/or day programming. Training focuses on reducing the challenging behaviors while increasing the socially appropriate behaviors. Training can include, but is not limited to, social skills, anger management, daily living skills, problem solving, conflict resolution, relaxation skills, symptom and medication management, pre-vocational skills, and healthy relationship skills.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals

The goal is to decrease potential readmission to psychiatric facilities and to stabilize the individual within the home and community setting and to provide intensive behavioral services to increase individual, family, and community safety and to address needs that will keep the individual in the home and community.

The Region 9 Community Needs Assessment highlights that “an inadequate supply of behavioral health services is one of the most significant unmet health needs” of our community (Collins, RHP 9 Community needs assessment report, 2012). The implementation of a Site-

based behavioral day program will address the community needs outlined in this assessment by maintaining individuals in their homes while increasing relevant and effective services to those individuals and their caregivers. This model will decrease the time and cost associated with multiple hospitalization/emergency department visits, involvement with criminal justice system and institutionalization.

Additionally, this project meets the regional goal of coordinated care for patients with behavioral health needs.

Challenges

According to the Texas Council for Developmental Disabilities (TCDD), approximately 475,265 people in the state of Texas are diagnosed with a Development Disability. An APA task force estimated that 30-70 percent of persons diagnosed with a developmental disability will experience the effects of a mental health condition at some point in their lifetime. In a 2009 study published in the American Association on Intellectual and Developmental Disabilities, it was estimated that 4-10% of individuals incarcerated also have a developmental disability. Once incarcerated, these individuals rarely receive specialized services, are at higher risk for victimization by other inmates, and may have more difficulty following rules resulting in longer sentences and lower likelihood of parole. Additionally, once released, this population receives little to no services increasing the rate of recidivism.

The Texas Department of Aging and Disability Services (DADS) operates 13 state supported living centers in the state of Texas. These state supported living centers provide 24-hour residential services to approximately 4,070 individuals with intellectual and developmental disabilities who are medically fragile or who have behavioral problems. These faculties have long faced overcrowding and funding cuts, resulting in returning consumers to the community without the skills needed to be successful.

5-Year Expected Outcome for Provider and Patients

- Recruit and train community health workers to serve in the treatment center
- Identify 16 at-risk people with developmental disabilities and enroll with site-based program.
- Increase number of people with developmental disabilities served by site based program by 24 over baseline.
- Increase number of people with developmental disabilities served by site based program by 32 over baseline.
- Increase number of people with developmental disabilities served by site based program by 40 over baseline.

Starting Point/Baseline

Baseline for measures (clients served, number of encounters, and number of trained staff) is zero. Hiring, training of staff and enrollment of the initial 16 clients will occur in DY 2. Program census will increase each year by 8.

Rationale

As described in the Region 9 Community Assessment (Section IV Behavioral Health), there are insufficient community based programs that provide crisis intervention and stabilization services to effectively and efficiently reduce the utilization of higher levels of care (i.e. ERs, hospitals, correctional facilities, and State Support Living Facilities). A site-based behavioral day treatment program for clients with developmental disabilities will allow Metrocare to utilize its specially trained staff to assist in crisis situations and provide the ongoing services needed to avoid crisis in the future. This approach to treatment fosters treatment team approach with a focus on building adaptive skills and resolving client needs to ensure stabilization in the home.

Metrocare Services is the largest provider of mental health services in Dallas County. We serve approximately 1,000 people diagnosed with a developmental disability each month and 10,000 people diagnosed with a mental health disorder. To provide quality services to such a large population, we must implement programs that are proven to be effective with our families. Further, as a member of this community, we recognize the societal and financial impact that multiple psychiatric hospitalizations, CPS and/or juvenile justice involvement, and an individual's removal from home can have on a family and the greater community. The Site-Based Day Program will take a comprehensive, systematic approach to treating individuals with complex needs, providing intensive services to quickly establish stabilization and then work rigorously to assist the individual/caregiver with getting needs met to sustain safety and stabilization. Through the efforts of this program, there will be a decrease in the number of individuals readmitted to psychiatric hospitals, involved in the criminal justice system, or placed in State Supported Living facility.

Project Components

This project has five required project components including:

A. Assess size, characteristics and needs of target population

B. Review literature/experience with populations similar to target population to determine community based interventions that are effective in averting negative outcomes

C. Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes

D. Design models which include appropriate range of community-based services and residential supports

E. Assess the impact of interventions based on standardized quantitative measures and qualitative analysis

Each of these required components are addressed in the Project Proposal by:

A. Program Design, as outlined in Manual of Operations, will include information regarding target population based on evidence and experience.

B. Program Design, as outlined in Manual of Operations, will be based on information derived from literature review and agency experiences with target population, to determine effective and relevant interventions and services to offer through Day Program.

C. Use of real time data for rapid cycle improvement for continuous Quality Improvement; use of standardized tools (Metrocare Clinical Data System and the Achenbach) to determine decrease of out-of-home treatment episodes and increase in community-based services and client functioning/quality of life

D. Program Design, as outlined in Manual of Operations, will be based on information derived from literature review and agency experiences with target population, to determine effective and relevant interventions and services to offer through Day Program.

E. Use of standardized tools (Metrocare Clinical Data System and the Achenbach) to determine decrease of out-of-home treatment episodes and increase in community-based services and client functioning/quality of life.

The ADEBA Approach: The Archenbach System of Empirically Based Assessment (ASEBA) offers a comprehensive approach to assessing adaptive and maladaptive functioning. Developed through decades of research and practical experience to identify actual patterns of functioning, the ASEBA provides professionals with user-friendly tools. The ASEVA assesses competencies, adaptive functioning, and behavioral, emotional, and social problems from age 1 ½ to over 90. Numerous studies demonstrate significant associations between ASEBA scores and both diagnostic and special education categories. You can relate ASEBA directly to DSM-IV diagnostic categories by using the DSM-oriented scales for scoring ASEBA forms.

The Process Milestones chosen for the project were derived from the RHP Planning Protocol. A customized improvement milestone was created to evaluate the programs' success at reducing

out-of-home treatment episodes including stays at psychiatric hospitals, criminal justice centers or placement in residential treatment facilities. Metrocare chose to customize this improvement milestone because I-1 focuses only on admission/readmission to a criminal justice setting and would not capture the other facilities of focus. Milestone I-5, functional status, was not chosen as an improvement milestone because it would too closely measure a client's quality of life, which is Metrocare's identified Category 3 Improvement Target.

Unique community need identification numbers the project addresses

CN.5: Behavioral Health

How the project represents a significant enhancement to an existing delivery system reform initiative

This program will establish a special day program for individuals with behavioral needs. It will provide individuals in the BDP program a comprehensive support team that will help develop an intense individualized behavior treatment plan for the individual that will assist in reducing the challenging behaviors while increasing the socially appropriate behaviors. Training can include, but is not limited to, social skills, anger management, daily living skills, problem solving, conflict resolution, relaxation skills, symptom and medication management, pre-vocational skills, and healthy relationship skills. Additionally, by reducing the utilization rates of out-of-home treatment facilities, Metrocare will aid our community partners by alleviating the number of patients seeking services and allowing those providers to focus on those clients in critical need of inpatient type services, incarceration or residential treatment.

Related Category 3 Outcome Measure(s)

IT-10.1 quality of Life – as measured by the Archenbach System of Empirically Based Assessment (ASEBA)

The goal of the Site-based Day Program is to provide intensive services to those individual diagnosed with a developmental disability that have experienced a psychiatric hospitalization, interaction with the criminal justice system, high rates of emergency department utilization, or are at-risk for placement in a State Supported Living facility. Some individuals diagnosed with a developmental disability and mental illness require specialized supports to prevent institutionalization or incarceration. There are long lasting consequences to this population if they do not receive these specialized supports in order to function on a daily basis. These consequences can include inability to complete daily activities of living, physical/emotional/sexual abuse, deterioration of relationships with primary caregivers; and stigmatization due to involvement with the criminal justice system.

Research indicates that adequate outpatient services decrease hospital use for behavioral health issues; however many individuals who experience multiple hospitalizations and are

identified as at-risk for removal from home have a multitude of individual and caregiver needs that must be addressed for the individual to stabilize in the community. Thus, intensive services that are comprehensive, offering multiple services to address unique needs of the individual/caregiver must be provided. The services provided through an intensive behavioral program are proven effective at improving daily functioning, reducing hospitalizations and out-of-home placements while costing considerably less than expensive treatment episodes in the hospital, criminal justice system or residential treatment. These services will include comprehensive functional assessment, skills training, counseling, family/caregiver training, and if needed, psychiatric evaluation and medication management. Implementing this variety and intensity of services allows a holistic approach to treatment; teaching the clients life skills and coping strategies that allows them to remain in their homes, stabilized with an increased quality of life. To evaluate the program's success regarding improving a client's quality of life, the ASEBA will be used to assess progress from admission to discharge.

Relationship to Other Projects

This project is one element of the behavioral health services continuum of care and relates to all other projects that provide/enhance services along the continuum:

137252601.1.1
137252607.2.1
137252607.2.2
137250607.2.3
137250607.2.4

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

NA

Plan for Learning Collaboratives (if applicable)

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV-Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Metrocare Services determined the value of each project by comparing the budgeted cost of the specific project against the cost to the community should the services go unprovided. In regards to the site-based Behavioral Day program, the significant cost of hospitalization, emergency room visits, detainment in a correctional facility, and placement in a State

Supported Living Facility were used as comparison data against cost for the Behavioral Day program. The starting point/baseline for the program is zero, with a total census of 16 at the end of the first year. The total census of those served will increase each year by 8 individuals. It is estimated that participation in BDP will result in less than 10% returning to the ER or hospital, less than 5% involved with the criminal justice system, and less than 2% requiring placement in a State Support Living Facility in the future.

Endnotes/References

1. *Chapter 3: Emergency Mental Health Services for People with Developmental Disabilities.* Retrieved July 2012, from University of Washing Green Bay: http://www.uwgb.edu/bhtp/tools/DDBestPractices.pdf
2. Collins, S. (2012). *Regional healthcare Partnership 9: Community Needs Assessment Report*. *Information on Dual Diagnosis.* Retrieved July 2012, from NADD.org: http://thenadd.org/resources/inforamtion-on-dual-diagnosis/
3. *Organic Disturbances & Metal Retardation, Parkland Health and Hospital System.* Retrieved Aug 2012, from TXpricepoint.org: http://txpricepoint.org/Report.aspx?DRG=884&FacilityID=1130950
4. *Saving Minds, Saving Money Mental Health Funding.* Retrieved Aug 2012 from The Mental Health America of Texas: http://mhatexas.org
5. S. dosReis, E Johnson, D. Steinwachs, C. Rohd, E.A. Skinner, M. Fahey, A.F. Lehman. (2008), *"Antipsychotic treatment patterns and hospitalizations among adults with schizophrenia. Schizophrenia Research."* Volume 101, Issue 1: 304-311.
6. *Texas Council for Developmental Disabilities.* Retrieved July 2012, from Texas Council for Developmental Disabilities: http://www.txddc.state.tx.us
7. *Texas Institutions.* Retrieved Aug 2012, from CommunityNowFreedom.org: http://communitynowfreedom.org/Texas_Institutions.php

137252607.2.5	*2.13.1*	*Project Components: A-E*	*Title:* ***Site Based Behavioral Day Program for Personal with Developmental Disabilities***
Dallas County MHMR Center dba Metrocare Services			*137252607*
Related Category 3 Outcome Measures	*137252607.3.9*	*IT-10.1*	*Quality of Life*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 (P-2) Design community based specialized intervention for target population Metric(P2.1): Program plans based on evidence/experience and addresses project goals Goal: Establish Behavioral Day Program Data Source: BDP Manual of Operations Milestone 1 Estimated Incentive Payment (max amount): $284,481 Milestone 2 [P-3] Enroll and serve individuals in need of day treatment services. Metric 1 [P-3.1]: Serve 16 individuals with developmental disabilities. Baseline: Zero Goal: Identify 16 at-risk individuals with developmental disabilities to enroll in program Data Source: Metrocare clinical system Milestone 2 Estimated Incentive	Milestone 3 [P-3] Enroll and serve individuals in need of day treatment services. Metric [P-3.1]: Serve 24 individuals with developmental disabilities. Goal: Increase number of individuals served from 16 to 24. Data Source: Metrocare clinical system Milestone 3 Estimated Incentive Payment (max amount): $337,191 Milestone 4 (P-4) Evaluate and continuously improve interventions Metric (P-4.1) Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Goal: Use real time data for rapid-cycle improvement to guide continuous quality improvement Data Source: Metrocare Quality Management Department Milestone 4 Estimated Incentive Payment (max amount): $337,191	Milestone 5 [P-3] Enroll and serve individuals in need of day treatment services. Metric [P-3.1]: Serve 32 individuals with developmental disabilities. Goal: Increase number of individuals served from 24 to 32. Data Source: Metrocare clinical system Milestone 5 Estimated Incentive Payment (max amount): $278,899 Milestone 6 (P-4) Evaluate and continuously improve interventions Metric (P-4.1) Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Goal: Use real time data for rapid-cycle improvement to guide continuous quality improvement Data Source: Metrocare Quality	Milestone 7 [P-3] Enroll and serve individuals in need of day treatment services. Metric [P-3.1]: Serve 40 individuals with developmental disabilities. Goal: Increase number of individuals served from 32 to 40. Data Source: Metrocare clinical system Milestone 7 Estimated Incentive Payment (max amount): $296,003 Milestone 8 (P-4) Evaluate and continuously improve interventions Metric (P-4.1) Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Goal: Use real time data for rapid-cycle improvement to guide continuous quality improvement Data Source: Metrocare Quality Management Department Milestone 8 Estimated Incentive Payment (max amount): $296,004

137252607.2.5	*2.13.1*	*Project Components: A-E*	*Title:* ***Site Based Behavioral Day Program for Personal with Developmental Disabilities***	
Dallas County MHMR Center dba Metrocare Services				*137252607*
Related Category 3 Outcome Measures	*137252607.3.9*	*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)
Payment (max amount): : $284,481			Management Department Milestone 6 Estimated Incentive Payment (max amount): $278,899 **Improvement Milestone 1 (1-X) Admission/Readmission to higher levels of care** **Metric (1-X.1): Decrease patient utilization rates of out-of-home treatment facilities** **Baseline/Goal: Decrease out-of-home treatment episodes by 70% for those in service** **Data Source: Metrocare Clinical System** **Improvement Milestone 1 Estimated Incentive Payment: $278,899**	**Improvement Milestone 2 (1-X) Admission/Readmission to higher levels of care** **Metric (1-X.1): Decrease patient utilization rates of out-of-home treatment facilities** **Baseline/Goal: Decrease out-of-home treatment episodes by 80% for those in service** **Data Source: Metrocare Clinical System** **Improvement Milestone 2 Estimated Incentive Payment: $296,004**
Year 2 Estimated Milestone Bundle Amount: $ 568,963		**Year 3 Estimated Milestone Bundle Amount:** $674,382	**Year 4 Estimated Milestone Bundle Amount:** $836,697	**Year 5 Estimated Milestone Bundle Amount:** $888,011
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):				**$2,968,053**

Project Option 2.2.1: Denton County Diabetes Registry and Expanded Chronic Care Management among Low Income Diabetic Registry Patients

Unique Project ID: 136360803.2.1
Performing Provider Name/TPI: Denton County Health & Human Services/136360803

Summary Description

Denton County Health Department is a County funded program with a wide range of programs serving about 40,000 patients a year. Services include immunization, well child, prenatal care and primary care. There are two office locations and 4 providers with bilingual nursing and clerical support.

Intervention

The project will implement a chronic disease registry to track Medicaid and low income diabetic patients. This will facilitate a comprehensive listing of Medicaid and low income diabetes patients in Denton County. In addition, diabetes care will be provided incorporating the Chronic Care Model developed by Wagner. In this way diabetes clients will be contacted twice a month to encourage taking medications in accordance with physician's orders, keeping appointments, proper diets, exercise, and other self-management techniques to improve health outcomes.

Need for Project

Under the traditional care model, health outcomes for many diabetes patients are poor, at best. Too many are non-compliant with physician's orders. Too many fail to make and keep referral appointments for eye care and foot care. Too many experience serious consequences as result of their non-compliance. The Chronic Care Model will improve the likelihood of improved outcomes for those clients that will strive for self- management.

Target Population

The target population is diabetics who are low income or Medicaid recipients. There are an estimated 5,000 in Denton County.

Expected Benefit

The project will provide Chronic Care Model case management to 200 diabetic clients in DY3, DY4, and DY5.

Category 3 Outcomes

Our goal is to reduce the percentage of registry patients with poorly controlled HbA1c by 5% by the end of DY5.

Project Description

This project will identify Denton County low income residents who are diagnosed with diabetes. These individuals will be entered into a diabetes registry that will provide a

cumulative list of individual name, address, and contact information as well as basic health care identifying information. A consolidated list will be maintained at two Denton County Health Department (DCHD) locations, the Denton Clinic, and the Lewisville Clinic. The list will be comprised of individuals who have been diagnosed with diabetes and who are either Medicaid recipients, or those who have no insurance. This project will also implement and monitor improvements in diabetic care and clinical outcomes among low income Denton County residents especially emphasizing the role of self-management, which will be facilitated by case managers and behavioral coaches, working in conjunction with the more traditional providers.

It is expected that DCHD will enroll about 200 participants in the first year. Part of the challenge for this project will be to make other providers who see low income families aware of the project and invite them to consent to have their clients participate. Multiple strategies will be employed to accomplish this task, including making visits to hospitals and to physician groups to inform them of the project and to discuss the merits of a county-wide diabetes registry.

However, the initiation of a diabetes registry is only a small part of this project. By far, the greater challenge is incorporating the components of a health system transformation into the standard provision of health care for diabetics. The need for health system transformation in the area of diabetes care is tragically evident in the office of every family practice physician. Diabetes patients do not follow their physicians' orders. They do not take their medications as ordered. They do not receive the specialty foot care that they need, although referrals are made. They do not lose weight, as their physicians order. And they do not test their blood sugar as their physicians order. Health care plans don't work in patients who do not follow them.

This project proposes to transform the traditional plan of care with a team approach, incorporating many of the components of the Chronic Care Model developed by Wagner. This approach will especially emphasize the role of self-management, which will be facilitated by case managers and behavioral coaches, working in conjunction with the more traditional providers. Rather than a monthly or quarterly physician office visit, the transformational approach will supplement the office visit with email contact, phone calls and home visits by the case management team on a bi-weekly basis.

In this way, the substantial benefits of self-management can be optimized, as the case management team provides bi-weekly encouragement for patients to follow their doctor's orders and make the difficult lifestyle changes that are so essential to improving their health outcomes. In addition to their bi-weekly one on one client contacts, the case management team will encourage participation in periodic diabetes group education and support meetings. In this way, patients can also benefit from the experiences of other motivated patients to grow in their desire and ability to self-manage. They will still keep all physician visits and remain committed to follow doctor's orders, but the entire approach becomes much more collaborative in nature, taking full advantage of the medical skills of the physician. But also incorporating the ability of the case management team to motivate the patient, educate the

patient, and in the process, help to greatly improve the compliance of the patient. This collaborative approach has shown great promise in the improvement of chronic disease outcomes.

Goals and Relationship to Regional Goals

The goal of this project is to implement the Chronic Care model among low income diabetes patients in Denton County. This project will implement and monitor improvements in diabetic care and clinical outcomes among low income Denton County residents especially emphasizing the role of self-management, which will be facilitated by case managers and behavioral coaches, working in conjunction with the more traditional providers. The goal is to substantially improve the clients' ability to self-manage their condition. This will result in improvements in key indicators such as blood pressure and HbA1c levels. Furthermore, with the routine contact and encouragement provided by the case management team, other important factors such as keeping specialty appointments for foot and eye care will also show improvement. These improved health status indicators will likely translate into reduced health care expenditures.

RHP 9 regional goals include improved access to care, improved care coordination and management and improved performance and outcomes. This project meets the regional goals of improved quality of care by improving care management and coordination for chronic conditions.

Challenges

Several major challenges are expected. The most formidable is the reality that diabetic patients are notoriously non-compliant. Their tendency is not to do the things that their physicians order. This is especially true while they are feeling good. Although the disease process may be doing severe damage to their bodies, they feel ok for the time being, and choose not to make the lifestyle changes that are necessary to effectively combat the disease. This attitude will be the focus of the health care team that works with this project. The chronic disease model that employs a broader range of health professionals, with considerably more patient contact, has a better chance to overcome this challenge.

5-year Expected Outcome for Provider and Patients

The outcome of this project is the development and implementation of a registry and multi-disciplinary care team approach based on the Chronic Care Model to effectively and successfully manage the chronic conditions of low income diabetic patients, ultimately improving clinical indicators and health outcomes for these patients. It is anticipated that through the use of the Chronic Care model, low income diabetic clients will improve their ability to participate in their care and grow in their capacity for self-management. Important indicators such as HbA1c levels will be expected to improve substantially as the case

management teams interact with clients on a regular basis and encourage therapeutic compliance. In addition referrals to specialists for foot care and/or eye care will be kept on a more consistent basis and as a result of these interventions; health care expenditures will be decreased although health status will be improved.

The ability to demonstrate improved diabetes health outcomes through the use of the Chronic Care teams in Denton County will be a significant development in terms of the management of diabetes in low income Denton County residents. It will document the usefulness of the team approach and the importance of providing sustained encouragement and case management to clients whose conditions demand substantial lifestyle changes. It is expected that the outcomes will result in improved self-management skills, improved health status, and reduced health care expenditures.

Starting Point/Baseline

There are an estimated 60,000 diabetics in Denton County. Over 5,000 would clearly fall within the low income population that is the target of this project. The number is probably even larger since minority families have an even higher prevalence rate for diabetes. But a conservative estimate of the target population for this project is well over 5,000 low income individuals with diabetes. The identification of a diabetes management team to help diabetic patients grow in their ability to self-manage their condition would be a significant development in diabetes care for non-compliant patients, and a substantial means of reducing the long term costs associated with diabetes. The components of this project are to: establish low income Denton County Diabetes Registry, expand chronic care model to primary care clinics, identify and manage registry patients, enroll registry patients in chronic care programs, and to ultimately improve clinical outcomes. Baseline starting point is 10/1/2012-9/30/2013.

Rationale

There are over 25.8 million people in America or 8.3% of the population that have diabetes in 2010 (National Diabetes Fact sheet, 2011). Diabetes is a risk factor for heart disease and if not controlled through insulin therapy can lead to death. The prevention of diabetes is within the Affordable Care Act of 2010 and the monitoring of diabetes in America is defined in the Catalyst to Better Diabetes Care Act of 2009, which is in the Affordable Care Act. The CDC reports that 67% of those that have diabetes also have high blood pressure and are at risk of vision loss, kidney failure, and amputations of legs or feet. The cost of diabetic care in 2007 according to the CDC was 174 billion dollars with 116 billion due to direct medical costs and 58 billion due to indirect medical costs. The prevalence of adult diabetes cases has increased from 1980 to 2010 in America. There are preventive care practices for those that are diagnosed with diabetes, such as flu vaccination, attendance to a diabetes self-care management class, checking HbA1c levels at least twice a year, annual eye exams, annual foot exams and daily monitoring of glucose. A survey of adults usage of these preventive care practices indicate 50 percent receive a flu vaccine, 58 percent attend a self-management class, 69 percent check HbA1c levels, 68 percent get an annual foot exam, 64 percent of adults check daily glucose and 63 percent get an annual eye exam. Many diabetic patients are noncompliant with preventive care practices (Diabetes

report Card, 2012). Disease and case management are effective in increasing preventive diabetic care. Disease management was developed to reduce the short term and long term health complications of chronic diseases like diabetes. Disease management identifies the population with diabetes, establishes standards of care for the disease, manages those that have disease, and monitors the progress of the disease. Case management is part of disease management and encourages those with the disease to follow the standards of care. According to the CDC Guide to Community Preventive services both disease management and case management improve HBA1c control, screening for diabetic retinopathy, screening for foot lesions, and screening for peripheral neuropathy (The Effectiveness of Disease and Case Management for People with Diabetes, 2002).[309][310][311]

Project Components

Core components for Project 2.2.1 include:

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

Unique community need identification numbers the project addresses

[309] Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.
[310] Centers for Disease Control and Prevention. *Diabetes Report Card 2012*. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2012.
[311] The effectiveness of disease and case management for people with diabetes: a systematic review. Norris SL, Nichols PJ, Caspersen CJ, Glasgow RE, Engelgau MM, Jack Jr. L, Isham GJ, Snyder SR, Carande-Kulis VG, Garfield S, Briss P, McCulloch D, Task Force on Community Preventive Services., American Journal of Prevention Medicine. Vol 22 No 4S, pp 15-38.

CN.9 Chronic Disease Management

How project represents a a new initiative

This is a new project designed to improve chronic disease management among the Denton County low-income diabetic population.

Related Category 3 Outcome Measure(s)

OD-1: Primary Care and Chronic Disease Management

- IT-1.10 "HbA1c poor control" will be used as the project outcome measure.

Reasons/Rationale for selecting outcome measures

Poorly controlled blood glucose levels may cause life-threatening and/or life-ending complications. This measure facilitates the prevention and long-term management of high blood sugar levels for patients with diabetes. Effective management of this clinical indicator will reduce co-morbid complications and contribute to improved disease management. Therefore, it was selected as the Category 3 Outcome measure for assessment.

Relationship to Other Projects

There are no similar projects submitted by Denton County

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborates

RHP 9 projects related to chronic care management include the projects listed below:

Performing Provider	Unique Project	Project Option
Baylor University Medical Center	139485012.2.2	Expand Chronic Care Management Model – Diabetes (HbA1c poor control, BP control, foot exam)
Baylor Medical Center at Garland	121790303.2.2	
Baylor Medical Center at Irving	121776204.2.2	
Trinity Medical Center (Baylor-Carrollton)	195018001.2.1	
Children's Medical Center	138910807.1.3	Implement ped. disease registry – asthma
Methodist Charlton Medical Center	126679303.2.1	Expand Chronic Care Management Model – Diabetes (30-day readmission, Hba1c, BP control)
Methodist Dallas Medical Center	135032405.2.1	
Methodist Richardson Medical Center	209345201.2.1	
Parkland Health & Hospital System	127295703.1.3	Implement chronic care registry (Diabetes – retinal eye exam, 30-day readmissions)
Parkland Health &Hospital System	127295703.2.4	Expand Chronic Care Management Model – Diabetes (reye exam; 30-day readmissions)
Texas Health Presbyterian Hospital Denton	020967801.2.2	Expand Chronic Care Management Model: Diabetes (HbA1c, 30 day readmissions)
Texas Health Presbyterian Hospital Kaufman	094140302.2.2	
UTSW – Faculty Practice Plan	126686802.2.2	Expand Chronic Care Management Model (Diabetes: HbA1c; All Cause Readmissions)

Denton County will participate in learning collaboratives as appropriate.

Project Valuation

Denton County Health Department has proposed to implement the chronic care model as a means of improving patients' ability to manage their diabetes. In doing so, health outcomes will be improved, and at the same time the costs associated with their care will be substantially reduced. The most reliable diabetes data are from 2007, when a total cost of $174 billion was assigned to an estimated 25.8 million diabetics. (National Diabetes Fact Sheet, 2011) That computes to an average of $6,744 per diabetic. But those are 2007 dollars. The present project period begins in 2013 and goes to 2017. A more accurate cost per patient could be estimated at $10,000, based upon an ever increasing cost of medical care. But this estimate is for all US diabetics, most of whom have health insurance and adequate access to care.

The Denton County Health Department project addresses only Medicaid and uninsured diabetics. This specific group of clients has substantially less access to health care; they are notoriously non-compliant; and they frequently utilize hospital emergency departments in lieu of primary care providers. Their health care costs might be estimated at 2 or even 3 times higher than the average diabetic. If Medicaid and uninsured patients are estimated at double the average cost for the project period, then a cost of $20,000 per diabetic might be a reasonable projected cost.

Using this projection, the estimated costs of care for the 600 diabetic patients that are included in this proposal would be 600 x $20,000 which equates to $12,000,000. If use of the chronic care model results in improved self-management, better patient compliance and improved health outcomes, a reduction in per person health care costs might be 50%. The resultant savings would amount to $6,000,000 which is $1 million more than the cost of the project. So the project might pay for itself, save an addition million in health care costs, and provide a model for care to Medicaid and uninsured diabetics that might result in far more substantial savings and improved health outcomes.

Unique Identifier: *136360803.2.1*	***RH PP Reference:*** *2.2.1*	***Project Components:*** *2.2.1*	***Title:*** *Denton County Diabetes Registry and Expanded Chronic Care Management Among Low Income Diabetic Registry Patients*
Denton County Health & Human Services Department			*136360803*
Related Category 3 Outcome Measures:	*136360803.3.1*	*IT-1.10*	*IT-1.10: 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-X1] Compose & establish low income Denton County Diabetes Registry. Metric 1: P-X1.1 Registry Documentation. Baseline 0 Goal: Complete registry Data Source: Medicaid and low income diabetic patients in Denton County Milestone 1 Estimated Incentive Payment (max amount): $25,160 **Milestone 2** [P-1] Expand the Chronic Care Model to primary care clinics who treat registry patients. <u>Metric 1:</u> [P-1.1] Increase number of primary care clinics using the Chronic Care model for registry patients. Baseline 0 Goal: 2 (100% of DCHD Clinics) Data Source: Demonstrated plan documentation Milestone 2 Estimated Incentive Payment (max amount): $25,160	**Milestone 5** [P-9] Develop program to identify and manage chronic care patients needing further clinical intervention. <u>Metric 1</u>: [P-9.1] Increase number of registry patients identified as needing screening test, preventive tests, or other clinical services. a) Numerator: number of patients identified and subsequently receiving needed tests or other clinical services. b) Denominator: total number of registry patients. Baseline 0 Goal: Identify all registry patients needing further clinical intervention Data Source: Registry, health record, internal data systems. Milestone 5 Estimated Incentive Payment (max amount): $549,414 **Milestone 6** [P-10] Expand and document interaction types	**Milestone 7** [I-17] Apply the Chronic Care Model to registry diabetes patients in Denton County needing further clinical intervention. <u>Metric 1</u>: I-17.1 Increase percentage of registry needing further clinical intervention enrollment in Chronic Care Model management programs. a) Numerator: Number registry patients enrolled in Chronic Care Model management b) Denominator: Total number registry patients. Baseline: 0 Goal: Increase Chronic Care Model management program participants by 20%, Data Source: Registry, health record, internal data systems. Milestone 7 Estimated Incentive Payment (max amount): $587,745 **Milestone 8** [I-18] Improve the percentage of Chronic Care Model management patients with self-	**Milestone 9** [I-X1] Improved diabetes related complications of diabetic registry patients among those Chronic Care Model management. <u>Metric 1</u>:[I-X1.1] Improved BP control of clients receiving case management over time a) Numerator: Number registry patients enrolled in Chronic Care Model management with BP control improvement. b) Denominator: Total number registry patients enrolled in Chronic Care Model management. Baseline: 0 Goal: Improve BP Control by at least 10% of clients receiving case management overtime, Data Source: Registry, health record, internal data systems <u>Metric 2</u>: [I-X1.2] Increase number of eye exams among clients receiving case management over time. a) Numerator: Number registry

Unique Identifier: *136360803.2.1*	***RH PP Reference:*** *2.2.1*	***Project Components:*** *2.2.1*	***Title:*** *Denton County Diabetes Registry and Expanded Chronic Care Management Among Low Income Diabetic Registry Patients*
Denton County Health & Human Services Department			*136360803*
Related Category 3 Outcome Measures:	*136360803.3.1*	*IT-1.10*	*IT-1.10: 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 3 [P-2] Train staff in the Chronic Care Model. Metric 1: [P-2.1] Increase percent of staff trained. Baseline 0 Goal: 50% of DCHD Clinic Staff Data Source: Demonstrated plan documentation Milestone 3 Estimated Incentive Payment (max amount): $25,160 **Milestone 4** [P-3] Develop comprehensive care management program for registry patients. Metric 1 [P-3.1]: Documentation of Care management program. Baseline 0 Goal: Complete development of management program Data Source: Demonstrated plan documentation Milestone 4 Estimated Incentive Payment (max amount): $25,161	between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types among registry patients. Metric 1: P-10.1 Number of telephone and home visits, other interaction types. a) Numerator: number of telephone and home visits, other interaction types among registry patients. b) Denominator: total number of registry patients. Baseline 0 Goal: Implement bi-weekly contacts among the 20% of registry patients from Milestone 5. Data Source: Registry, health record, internal data systems. Milestone 6 Estimated Incentive Payment (max amount): $549,414	management goals Metric 1: I-18.1 Increase percentage of ~~registry~~ Chronic Care Model management patients with self-management goals of foot & Eye exam referral utilization. a) Numerator: Number Chronic Care Model management ~~registry~~ patients with self-management goals for foot & eye exam referral utilization b) Denominator: Total number ~~registry patients.~~ patients enrolled in Chronic Care Model management Baseline:0 Goal: Increase number of registry patients in Chronic Care Model management programs with self-management goals of foot & eye exam referral utilization by 20%. ~~a)~~ Data Source: Registry, health record, internal data systems Milestone 8 Estimated Incentive Payment (max amount): $587,745	patients enrolled in Chronic Care Model management who receive eye exams. b) Denominator: Total number registry patients enrolled in Chronic Care Model management. Baseline: 0 Goal: Increase number of eye exams among clients receiving case management by at least 10% of overtime. Data Source: Registry, health record, internal data systems Metric 3: [I-X1.3] Increase number foot exams among clients receiving case management over time. a) Numerator: Number registry patients enrolled in Chronic Care Model management who receive foot exams. b) Denominator: Total number registry patients enrolled in Chronic Care Model management. Baseline:0 Goal: Increase number foot exams among clients receiving case

Unique Identifier: *136360803.2.1*	***RH PP Reference:*** *2.2.1*	***Project Components:*** *2.2.1*	***Title:*** *Denton County Diabetes Registry and Expanded Chronic Care Management Among Low Income Diabetic Registry Patients*
Denton County Health & Human Services Department			*136360803*
Related Category 3 Outcome Measures:	*136360803.3.1*	*IT-1.10*	*IT-1.10: 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)**
			management by at least 10% overtime. Data Source: Data Source: Registry, health record, internal data systems Milestone 9 Estimated Incentive Payment (max amount): $1,135,739
Year 2 Estimated Milestone Bundle Amount: $1,000,641	**Year 3 Estimated Milestone Bundle Amount:** $1,098,828	**Year 4 Estimated Milestone Bundle Amount:** $1,175,490	**Year 5 Estimated Milestone Bundle Amount:** $1,135,739
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):			**$4,410,698**

Project Option 2.7.6 – Disease Prevention Program: Denton County Immunization Project

Unique Project ID: 136360803.2.2
Performing Provider Name/TPI: Denton County Health & Human Services/136360803

Summary Description

Denton County Health Department is a County funded program with a wide range of programs serving about 40,000 patients a year. Services include immunization, well child, prenatal care and primary care. There are two office locations and 4 providers with bilingual nursing and clerical support.

Interventions

This project will promote and provide preventive immunizations to adult Medicaid and adult low income individuals in Denton County. The immunizations will include meningitis, shingles, pneumonia, influenza, hepatitis A, hepatitis B, pertussis, tetanus, and measles, mumps, and rubella.

Need for Project

State funding reductions have eliminated the availability of these vaccines to adults. But even when the vaccines were available, adults were never the target of any preventive program. They might be served, if the vaccines were available, but they were not the target population from a health promotion perspective. Children were always the primary focus. Between 2005 and 2010 there were 5,895 hospitalizations in Denton County just for bacterial pneumonia. Expanded use of vaccine can prevent many of these hospitalizations.

Target Population

The target population is adult low income and adult Medicaid recipients who may be at risk for the diseases which the vaccines prevent.

Expected Benefits

The project will administer preventive vaccines to 200 low income and Medicaid adults during DY3, DY4, and DY5.

Category 3 Outcomes

Our goal is to reduce the percentage of clinic clients hospitalized by pneumonia or influenza by 5% by the end of DY5.

Project Description

This project proposes to target low income adult Denton County Health Clinic clients with vaccines that will help them stay healthy, stay on the job, and prevent disease and hospitalization.

Every year vaccine preventable diseases in adults account for millions of dollars in health care expenditures. Between 2005 and 2010, there were 5,895 hospital admissions in Denton County for bacterial pneumonia. The cumulative cost of just these hospital admissions was over $230 million dollars. Pneumonia vaccine can prevent a large percentage of these hospitalizations which collectively cost essentially $486 for every adult in Denton County. Expanded use of adult immunizations can prevent disease and substantially reduce health care costs. Another very obvious need for expanded immunization, especially among adults, is in the area of influenza. Influenza and pneumonia combined are the sixth highest cause of death in Denton County. Many of these cases are among individuals who are over 50 years of age and are known to be at increased risk. Nevertheless, immunity levels among this population remain in the area of 50% and consequently, too many Denton County residents become statistics that testify to the need for a vigorous adult immunization program.

In previous years the Texas Department of State Health Services provided many adult vaccines to local health departments. Legislative funding cuts from a year ago have eliminated the provision of adult vaccines to local health departments. The vaccination of adults, like the vaccination of children, produces predictable outcomes that are well documented. Increased vaccination results in increased levels of immunity and reduced morbidity and mortality. A clearly associated secondary outcome is reduced health care expenditures.

This project proposes to target low income adult Denton County Health Clinic clients with vaccines that will help them stay healthy, stay on the job, and prevent disease and hospitalization. The specific vaccines to be administered include: meningitis, shingles, pneumonia, influenza, hepatitis A, hepatitis B, pertussis, tetanus, and measles, mumps, and rubella. Provision of these vaccines, especially to the low income families of Denton County is a highly cost effective proposition. Families that are struggling to put food on the table, and who must postpone a trip to town because gasoline prices are too high are not likely to incur the costs associated with these vaccines. The costs are prohibitive for those struggling to get by. The ability for public health to provide these vaccines to individuals who would not otherwise receive them is central to the mission of public health. It is perfectly preventive in nature, and will help to protect the vaccine recipients, as well as the community in general. In the process, thousands of dollars in health care expenditures can be avoided.

This project proposes to target low income Denton County adults with vaccines that will help them stay healthy, stay on the job, and prevent disease and hospitalization. The specific vaccines to be administered include: meningitis, shingles, pneumonia, influenza, hepatitis A, hepatitis B, pertussis, tetanus, and measles, mumps, and rubella. Provision of these vaccines, especially to the low income families of Denton County is a highly cost effective proposition. Families that are struggling to put food on the table, and who must postpone a trip to town because gasoline prices are too high are not likely to incur the costs associated with these vaccines. The costs are prohibitive for those struggling to get by. The ability for public health to provide these vaccines to individuals who would not otherwise receive them is central to the mission of public health. It is perfectly preventive in nature, and will help to protect the vaccine

recipients, as well as the community in general. These vaccinations will reduce the burden of disease and in the process, thousands of dollars in health care expenditures can be avoided.

This project plans to use a team of 5 individuals, a project manager, 2 LVNs and 2 clerical support staff. The majority of the vaccines will be administered at the two Denton County Health Department clinic locations, one in Denton and one in Lewisville. Occasionally, off site clinics may be arranged to meet special community needs. During the project period, it is expected that over 12,000 individuals will be vaccinated.

Goals and Relationship to Regional Goals

The goal of this project is to target low income Denton County adults with vaccines that will help them stay healthy, stay on the job, and prevent disease and hospitalization. The specific vaccines to be administered include: meningitis, shingles, pneumonia, influenza, hepatitis A, hepatitis B, pertussis, tetanus, and measles, mumps, and rubella. Provision of these vaccines, especially to the low income families of Denton County is a highly cost effective proposition. This project will create a vaccination team, establish outreach, and increase awareness to maximize voluntary immunizations among low income populations in Denton County, Texas. The most immediate goal of the project is to administer 12,000 doses of vaccines to low income Denton County families. In doing so, cases of disease will be prevented. Hospitalizations will be avoided; and substantial savings in health care expenditures may be experienced.

This project meets the regional goals of improved care coordination and management through primary and preventive care and reduced hospitalizations by ensuring low income Denton County residents are immunized.

Challenges

Motivating individuals to obtain preventive vaccines is the major challenge. Preventive strategies are not traditionally embraced by low income populations. Understandably, how to provide supper for the family takes precedence over how to prevent a disease that may not occur for several years, if at all. Thus convincing low income families of the importance of preventive immunizations will be a substantial challenge. The ability to integrate vaccine administration with other health visits may provide a helpful approach. And certainly making the vaccines available at a very low cost will help as well.

5-Year Expected Outcome for Provider and Patients

The outcome of this project is to increase the proportion of low income Denton County adults with vaccines that will help them stay healthy, stay on the job, and prevent disease and hospitalization, thereby, reducing hospitalizations for the combined flu and pneumonia rates among this population. This DSRIP goal is to reduce overall hospitalizations for the combined flu

and pneumonia rates by 5% overall by year 5. This outcome will demonstrate the ability to focus services on a particular at risk population and bring about improved health outcomes within a few short years. The cost effectiveness of vaccines is well documented. The ability to expand the model to adults and demonstrate reductions in hospitalization rates in areas such as bacterial pneumonia and influenza can be particularly helpful in formulating health policy.

Starting Point/Baseline

Establish and implement immunization team. At present, no baseline exists; however, as the project begins to serve clients, immunity levels will be recorded for the various vaccine categories so that comparisons can be made in subsequent years. Baseline starting point is 10/1/2012-9/30/2013.

Rationale

Immunization or vaccination is a large success story in public health. An organization called Healthy People sets national goals every ten years for the improvement of health in America. The organization has a 2020 goal for increasing vaccinations of multiple diseases such as meningitis, shingles, pneumonia, influenza, hepatitis A, hepatitis B, pertussis, tetanus, measles, mumps, and rubella (Healthy people 2020 objectives, 2012). The vaccination of children by routine immunization schedules saves 33,000 lives, prevents 14 million cases of disease, reduces direct health care costs by $9.9 billion, and saves $33.4 billion in indirect costs according to the Healthy People organization. The vaccination success story has not eliminated these diseases because there are over 30,000 deaths and 400,000 cases of illness in the United States that could be prevented with community programs according to the CDC. The CDC has a Guide to Community Preventive services that have three categories of interventions for increasing vaccination in a community, which are increasing community demand for vaccination, enhancing access to vaccination services, and provider-based interventions. The community demand can be increased by reminding clients on vaccinations through calls, email or regular mail, requiring vaccination in daycare, schools and college attendance, and community education. The access to vaccination services can increase by reducing out-of-pocket costs for vaccinations, expanding access to vaccinations in health care facilities, and more vaccination opportunities in non-medical settings. The provider can increase vaccination by reminding patients on vaccinations during provider visits, standing orders for vaccination by providers and increased provider education on vaccines (Reviews of Evidence Regarding Interventions to Improve Vaccination Coverage in Children, Adolescents, and Adults, 2000).[312][313][314]

[312] Ndiaye SM, Hopkins DP, Shefer AM, Hinman AR, Briss PA, Rodewald LE, Willis B, Task Force on Community Preventive Services. Interventions to improve influenza, pneumococcal polysaccharide, and hepatitis B vaccinations coverage among high-risk adults: a systematic review. American Journal of Prevention Medicine. 2005. Vol 28 No 5S, pp 248-279.

[313] Briss PA, Rodewald LE, Hinman AR, Shefer AM, Strikas RA, Bernier RR, Carandes-Kulis VG, Yusuf HR, Ndiaye SM, Williams SM, Task force on Community Preventive Services. Reviews of evidence regarding interventions to improve vaccination coverage in children, adolescents and adults. American Journal of Prevention Medicine. 2003. Vol 18 No 1S, pp 97-140.

An important vaccination that is used at a national level is for influenza, which has caused 114,000 excess hospitalizations and 36,000 deaths according to the CDC. There is an increase in mortality for patients older than 65 and those that have chronic disease because of complications with influenza. In 2000, the influenza vaccination coverage for adults with high-risk conditions was 33%, which was below the Healthy People 2010 goal of 60% (Interventions to Improve Influenza, Pneumococcal Polysaccharide, and Hepatitis B Vaccination Coverage among High-Risk Adults, 2005). This new community program reinstates the adult safety-net vaccination program that was eliminated in early 2011. The Texas Department of State Health Services discontinued the purchase of vaccine for local health departments based on budget cuts and a newly-interpreted rule from the Centers for Disease Control regarding the use of the Vaccine for Children (VFC) vaccine supply program. Under the new interpretation, underinsured and uninsured adults were no longer covered. The result of this rule change was the discontinuation of low/no-cost immunization programs for adults who needed them most.

Project Components

The core requirements of Project Option 2.7.6 "Other Projects" Option: Denton County Immunization Project includes the following:

a) Design and implement Immunization teams to administer vaccines to target populations.
b) Ensure that target population can access immunization center teams in person or by phone or email.
c) Increase target population participation through education, community alliances, contact with area providers, announcements, and community events.
d) Implement projects to generate target population awareness of the necessity to be vaccinated.
e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project or a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Expanded use of adult immunizations can prevent disease and substantially reduce health care costs by reducing hospitalizations. The health impact of flu and pneumonia is substantial. Vaccines are the most effective way to prevent severe illness and complications. Every year vaccine preventable diseases in adults account for millions of dollars in health care expenditures. Between 2005 and 2010, there were 5,895 hospital admissions in Denton County for bacterial pneumonia. The cumulative cost of just these hospital admissions was over $230

[314] Healthy people 2020 summary of objectives: Immunization and Infectious Diseases. Available at: http://healthypeople.gov/2020/topicsobjectives2020/pdfs/Immunization.pdf. Accessed October 12, 2012

million dollars. Pneumonia vaccine can prevent a large percentage of these hospitalizations which collectively cost essentially $486 for every adult in Denton County. The components of this project are to: develop an immunization program for low income adult clinic clients, participate in learning engagements with other similar providers, identify low income clinic clients in need of vaccination, provide vaccinations, and ultimately to reduce admission rates among clinic clients for vaccine preventable diseases such as pneumonia and influenza.

Unique community need identification numbers the project addresses

CN.4 Primary Care

How the project represents a significant enhancement to an existing delivery system reform initiative

This is a new project designed to improve immunization levels among the Denton County low-income diabetic population

Related Category 3 Outcome Measure(s)

IT-2.10: Flu and pneumonia Admission Rate will be used as the project outcome measure.

Reasons/Rationale for selecting outcome measures

Expanded use of adult immunizations can prevent disease and substantially reduce health care costs by reducing hospitalizations. The health impact of flu and pneumonia is substantial; therefore, hospital admission rates for pneumonia or influenza was selected as the Category 3 Outcome Measure for assessment.

Relationship to Other Projects

There are no related projects for Denton County.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborates

As this is a specific initiative for Denton County residents, there are no other similar or related RHP 9 projects being submitted.

Denton County will participate in learning collaboratives as appropriate.

Project Valuation

Denton County has proposed to improve health outcomes for Medicaid and uninsured residents by expanding adult immunizations. The rationale for the use of vaccines to reduce health care costs is perhaps the best success story in public health. The cost reduction in the treatment of smallpox is quite dramatic. Similarly, health care expenditures for polio have been

all but eliminated as a direct result of the use of vaccines. DCHD outcomes for influenza and bacterial pneumonia immunization may not be quite as spectacular, but they are predictable and substantial.

Texas Department of State Health Services documents confirm 5,895 hospitalizations from 2005 to 2010 for bacterial pneumonia. The total hospital charges that resulted from these admissions was $233,417,472, an average of $39,596 per hospitalization. The DCHD proposal includes the vaccination of 1500 Medicaid recipients and uninsured residents for bacterial pneumonia. If these immunizations result in the prevention of 100 hospitalizations, the associated savings would be $3,959,600.

Similarly, influenza hospitalization costs would also reduced. Although influenza costs for hospitalization are not as great, there are more of them. A conservative cost estimate is $10,000 per influenza admission. Consequently, if the provision of 1500 doses of vaccine were to result in 100 fewer hospitalizations, the resultant savings would be about $1,000,000. Keep in mind the 1500 vaccinations would mean 1500 fewer individuals to spread influenza to other susceptibles, so 100 fewer hospitalizations is not a stretch.

These are only the hospitalization costs and do not take into consideration the costs related to health care providers, labs, pharmacy, etc. Furthermore, this is only two of the proposed 10 vaccines. These two vaccines alone could result in hospitalization savings of 4.9 million. Additional savings realized from pertussis, hepatitis A, hepatitis B, Zoster, and the other vaccines would surely result in savings of at least $1,000,000. That would bring the hospitalization savings to 5.9 million and another million could be anticipated in provider, laboratory, and pharmacy savings. So the total estimated savings would exceed 6.9 million from a program that costs only 5 million. Given the documented cost effectiveness of vaccine programs, this initiative to improve adult immunizations among Medicaid recipients and the uninsured is clearly cost effective.

Unique Identifier: *136360803.2.2*	***RH PP Reference:*** *2.7.6*	***Project Components:*** *2.7.6*	***Title:*** *Denton County Immunizations*
Denton County Health & Human Services Department			*136360803*
Related Category 3 Outcome Measures:	136360803.3.2	IT-2.10	*IT-2.10: Flu and pneumonia Admission Rate*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X1] Develop Immunization Program for low income adults 19+ years Metric 1 [P-X1.1]: Purchase vaccine to immunize targeted uninsured/ underinsured adult population ages 19+ Metric 2 [P-X1.2]: Employ staff members to provide adult vaccines in 2 locations Baseline 0 Goal: Complete development of immunization program. purchase vaccines, provide staff Data Source: Demonstrated plan documentation Milestone 1 Estimated Incentive Payment: $500,320 **Milestone 2** [I-5]: Identify number and percentage of low income adult clinic clients who need vaccine. Metric 1 [I-5.1] Develop baseline immunity levels among low income adults utilizing community clinics. Numerator: Number low income adult clinic clients vaccinated. Denominator: Total low income	**Milestone 3** [P-7] Participate in face to face learning meetings or seminars at least twice per year with other providers and the RHP to promote shared or similar projects Metric 1: P-7.1: Participate in semi-annual face to face meetings organized by the RHP. Organize semiannual meetings to familiarize Denton County providers with the adult immunization program Baseline 0: Goal: Attend or conduct at least 2 meetings to educate providers and exchange information Data Source: Demonstrated plan documentation Milestone 3 Estimated Incentive Payment (max amount): 1,098,828	**Milestone 4** [I-7] Improve immunity levels among adult low income clinic clients after immunization program implementation Metric 1: I-7.1: Increase baseline percentage of adult low income clinic clients vaccinated overtime. Numerator: Number low income adult clinic clients vaccinated. Denominator: Total number low income adult clients served by Denton County Health clinics. Baseline: Number and proportion low income adult clinic clients vaccinated. Goal: Increase immunity levels by 5% from baseline over time. Data Source: Documentation, Health records in community clinics serving low income adults, data systems Milestone 4 Estimated Incentive Payment (max amount): 1,175,490	**Milestone 5** [I- 7] Improve immunity levels among adult clinic clients after immunization program implementation Metric 1: I- 7.1: Increase baseline percentage of adult low income clinic clients vaccinated overtime. Numerator: Number low income adult clinic clients vaccinated. Denominator: Total number low income adult clients served by Denton County Health clinics. Baseline: Number and proportion low income adult clinic clients vaccinated. Goal: Increase immunity levels by 10% from baseline over time. Data Source: Documentation, Health records in community clinics serving low income adults, internal data systems Milestone 5 Estimated Incentive Payment (max amount): 1,135,739

Unique Identifier: *136360803.2.2*	***RH PP Reference:*** *2.7.6*	***Project Components:*** *2.7.6*	***Title:*** *Denton County Immunizations*
Denton County Health & Human Services Department			*136360803*
Related Category 3 Outcome Measures:	136360803.3.2	IT-2.10	*IT-2.10: Flu and pneumonia Admission Rate*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
adult clients served by Denton County Health Baseline 0 Goal: Establish baseline immunity levels, determine number and who needs vaccine Data Source: Demonstrated plan documentation Milestone 2 Estimated Incentive Payment: $500,321			
Year 2 Estimated Milestone Bundle Amount: $1,000,641	**Year 3 Estimated Milestone Bundle Amount:** $1,098,828	**Year 4 Estimated Milestone Bundle Amount:** $1,175,490	**Year 5 Estimated Milestone Bundle Amount:** $1,135,739
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):			**$4,410,698**

Project Option 2.8.6 - 24 Hour Psychiatric Triage Facility

Unique Provider ID: 135234606.2.1
Performing Provider Name/TPI: Denton County MHMR Center/135234606

Provider: Denton County MHMR Center is a state-funded not for profit outpatient mental health clinic serving as the mental health authority for Denton County. Denton County covers 952.98 square miles, has population of 662, 614, and has a rate of growth of 58% over the last 10 years . Denton County does not have an acute-care safety net hospital.

Interventions: This project will implement a 24-hour psychiatric triage facility to provide 24 hour care to individuals in crisis to decrease inappropriate ED usage.

Need for the Project: Denton County does not have an acute-care safety net hospital. The project will relieve the burden of treating psychiatric clients in the emergency room setting.

Target Population: Our target population is any individual experiencing a psychiatric crisis that does not require medical attention. Approximately 90% of our current clients are indigent or Medicaid eligible and we estimate that 60-75% of the clients of the psychiatric triage facility will also be indigent or Medicaid eligible. We intend to serve at a minimum 500 individuals in the psych triage facility by the end of DY 5.

Category 2 Expected Patient Benefit: Our goal is to increase efficiency of client care and decrease cost by streamlining care for individuals in a psychiatric crisis. The client will experience a decrease in wait time for assessment, and a decreased involvement from law enforcement in their care. These things will be of great benefit to the clients. The patient benefit includes serving at a minimum 500 individuals at the facility by the end of DY 5 and providing an average of 2.5 services per individual.

Category 3 Outcomes: IT 9.2- Our goal is to reduce inappropriate ED usage for behavioral health target population by 15% over baseline during DY 4 and 30 % in DY 5.

Project Description

Establish a 24 hour psychiatric triage facility to increase the capacity to provide psychiatric services, to better accommodate the high demand for triage services, and reduce inappropriate emergency room usage.

Goals and Relationship to Regional Goals

The project goal is the development of a 24 hour psychiatric triage facility that will link individuals in need of psychiatric services with appropriate care. Regional goals are to increase access to necessary behavioral health services.

Challenges

The challenges for this project include: lack of funding, lack of a public hospital, lack of voluntary and involuntary beds at state mental health facilities, lack of insurance for 17.2% of adults and 10.6% of children for individuals in Denton County, and lack of additional community resources to promote preventative behavioral health services [CN.5]. The county lacks community resources for behavioral health care assessment/services for indigent individuals outside of the Local Mental Health Authority.

The challenges will be overcome by establishing a 24 hour triage facility to serve individuals in psychiatric crisis. The facility will give people 24 hour access to psychiatric care outside of the hospital setting to reduce cost and reduce the demand on inpatient beds and Emergency Department (ED) space. The triage facility will provide quality and efficient access to care for patients who currently have to wait and go through several providers to access appropriate treatment. The starting point for the expansion and enhancement of behavioral health services will be developing 24 hour psychiatric triage services. Services include: assessment, medication management and referral, as indicated, to a higher level of care. The four year expected outcome of the project is to provide expanded behavioral health triage services through a centralized location, thus reducing potentially preventable admissions/readmissions to area hospitals and emergency rooms.

5-year Expected Outcome for Providers and Patients

Reduced inappropriate ED usage for targeted population - Behavioral Health/Substance Abuse

Starting Point/Baseline

In Denton County, those that are uninsured or underinsured have limited access to mental health services [CN.5]. The starting point for the expansion and enhancement of behavioral health services will be developing 24 hour psychiatric triage services. Services include assessment, medication management and referral, as indicated, to a higher level of care. The four year expected outcome of the project is to provide expanded behavioral health triage services through a centralized location, thus reducing potentially preventable admissions/readmissions to area hospitals and emergency departments. Denton County has the least amount of mental health funding per capita in the State of Texas. The emergency rooms, law enforcement, and the criminal justice system have an increased burden due to this lack of funding and resources. Current access to emergency crisis services is available by calling the access/crisis line. An intake may be scheduled or a mobile crisis team may go out to the community or emergency rooms for an emergency crisis screening. Approximately one third of these crisis screenings are done in the emergency rooms or in hospitals. Denton County does not have a public acute-care safety net hospital. Due to the lack of indigent mental health care

availability, there is a need for increased capacity for triage of psychiatric emergencies with the emphasis of preventing inappropriate emergency room use and linking individuals with appropriate care. Denton County MHMR Center will determine an appropriate baseline in DY3 of the project.

Rationale

The 24 Hour Psychiatric Triage Facility is a new initiative for Denton County MHMR Center. The rationale for the project is in the value of reducing Emergency Department (ED) admit/readmit rates and prevention of unnecessary ED, acute care, and criminal justice use [6]. This project will address the metrics associated with Right Care and Right Setting as required under 2.8.6 in the RHP planning protocol. This initiative will also enhance the opportunity for additional jail diversion [6, CN.7]. The community need for this project is due to lack of funding, lack of a public acute-care safety net hospital, lack of voluntary and involuntary beds at state mental health facilities, and lack of additional community resources to promote preventative behavioral health services [CN.5]. The county lacks community resources for behavioral health care assessment/services for indigent individuals outside of the Local Mental Health Authority. The United Way of Denton County, Inc. identified health needs and mental health services for depression as top findings in their assessment [CN.5]. The lack of health care access is attributed to a lack of insurance (2011: 17.2% adults and 10.6% children [CN.5]. The project will benefit local EDs by redirecting indiviudals without medical needs, but with psychiatric needs to our facility. In addition, it will cut down the amount of time law enforcement spends at residences and other community locations handling psychiatric crisis situations. The client will benefit because he/she will not experience the wait time he/she may experience currently at an ED when he/she is in psychiatric crisis. When individuals that have a mental health diagnosis receive treatment and are able to return to work the value to the community is increased by wages and taxable income [8, 4, 10]. Individuals that have a mental health diagnosis earn $16,000 dollars less annually than their non-diagnoses counterpart. This costs employers in the United States and other countries, including Australia, billions of dollars in lost revenue generation, and loss of labor force. Millions of dollars are also lost in income tax revenue. The Texas economy loses $5 billion annually due to mental illness mostly through loss of worker production [6, 11, 9, 13]. Effective community triage, referrals, and community treatment can reduce emergency room admission and readmission, acute care, as well as decreasing lost revenue and increased expenditure on avoidable incarceration. The cost of care for a person that has a mental illness is as follows: Incarceration $137 per day, ER $1265, state mental health hospital $400 per day; verses community cost of care for a person that has a mental illness: $12.00 per day. Appropriate triage can prevent incarceration, ER visits, acute care utilizations, and state hospital admits by appropriate referrals to the community mental health system [5]. Moreover, in an Integrated Care Collaboration model study, it was noted that nine frequent ER users over six years cost three million dollars to treat, seven of those nine had a mental illness [1, 2, 3, 4, 7, 12].

Project Components

There are no project components for Project Option 2.8.6

Unique community need identification numbers the project addresses

Community needs are addressed throughout the document.
CN 5 Behavioral Health
CN7 Behavioral Health and Jail Population

How the project represents a new initiative

The community does not currently have a 24-hour psychiatric triage service and this project will fulfill that need for care.

Related Category 3 Outcome Measure(s)

- IT-9.2: Reduce inappropriate ED usage for targeted population-Behavioral Health/Substance Abuse

Providing a psychiatric triage facility will lead to appropriate care for individuals with behavioral health and substance abuse emergencies that do not require medical attention. Often individuals seek treatment in EDs because they do not have other places to seek treatment or do not know where to seek treatment. The priority stems from a lack of resources in this county for low income health care services as evidenced by Denton County MHMR Center's growing

wait list for services and the high numbers of people seeking treatment for psychiatric services in emergency departments. Denton County MHMR Center's waiting list for behavioral health services is over 300 as of October 2012. Currently, Denton County has no public hospital and limited resources for indigent care [CN.5].

Relationship to other Project

- 2.8.3: Reduce potentially preventable admissions
- 2.8.4: Reduce potentially preventable readmissions

Related Category 4 Population-focused improvements

RD-5 Emergency Department

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

Related projects to improve access to behavioral health services in appropriate settings include:

Dallas County HHS	121758005.1.1: Behavioral Health Crisis Stabilization Services
Lakes Regional MHMR	121988304.1.1: Behavioral Health Crisis Stabilization Services

As appropriate, we plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The value of this project includes reducing ED admit/readmit rates and prevention of unnecessary ED, acute care, and criminal justice use [6]. This initiative will also enhance the opportunity for additional jail diversion [6]. When individuals that have a mental health diagnosis receive treatment and are able to return to work the value to the community is increased by wages and taxable income [8, 4, 10]. Individuals that have a mental health diagnosis earn $16,000 dollars less than their non-diagnosed counterpart annually. This costs employers in the United States and other countries, including Australia, billions of dollars in lost revenue generation, and loss of labor force. Millions of dollars are also lost in income tax revenue. The Texas economy loses $5 billion annually due to mental illness mostly through loss of worker production [6, 11, 9, 13]. Effective community triage, referrals, and community treatment can reduce emergency room admission and readmission, acute care, as well as decreasing lost revenue and increased expenditure on avoidable incarceration. The cost of care for a person that has a mental illness is as follows: Incarceration $137 per day, ER $1265, state mental health hospital $400 per day, and community cost of care for a person that has a mental illness: $12.00 per day. Appropriate triage can prevent incarceration, ER visits, acute care utilizations, and State Hospital admits by appropriate referrals to the community mental health system [5]. Moreover, in an Integrated Care Collaboration model study, it was noted that nine frequent ER users over six years cost three million dollars to treat and seven of those nine had a mental illness [1, 2, 3, 4, 7, 12]. In addition, through econometrics, we value the impact of this project to the community at $30,000,000, although Denton County MHMR Center is requesting a much smaller DSRIP valuation/incentive payment for this project.

End Notes/References

1. American Hospital Association. (2012). *Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes*. Retrieved from http://http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf

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12. Stone, J. & Hoffman, G. (2010). *Medicare hospital readmissions: Issues, policy options and PACA.* Retrieved from: http://www.hospitalmedicine.org/AM/pdf/advocacy/CRS_Readmissions_Report.df

13. Texas Council of Community Mental Health and Mental Retardation. Current pamphlet. *Building strong communities one person at a time*. Retrieved from http://www.txcouncil.com

14. United Way. (2011). *Denton county united way needs assessment*. Retrieved from http://www.unitedwaydenton.org/activities/community-assets-needs-assessment

135234606.2.1	*2.8.6*	*2.8.6*	*24 Hour Psychiatric Triage Facility*
Denton County MHMR Center			*135234606*
Related Category 3 Outcome Measure(s):	*135234606.3.1*	*IT-9.2*	*Right Care, Right Setting: 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-6]: Implement a program to improve efficiencies and/or reduce program variation. Metric 1 [P-6.1]: Performance improvement events. Data Source: Meeting minutes Baseline/Goal: Monthly meetings for performance improvement events. Milestone 1 Estimated Incentive Payment: $ 1,302,664 **Milestone 2** [P-15]: Participate in face to face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 2 [P-15.1]: Participate in semi-annual face-to-face meetings organized by RHP Data Source: Documentation of meetings. Baseline/Goal: Meetings twice per year Milestone 2 Estimated Incentive	**Milestone 3** [P-8]: Train providers/staff in process improvement. Metric 3a [P-8.1]: Number trained Data Source: Training Records Baseline/Goal: Train 100% of the staff Metric 3b [P-8.2] Number of trainings Data Source: Curriculum or other training schedules/materials. Baseline/Goal: Hold at least 2 trainings Milestone 3 Estimated Incentive Payment: $868,442 **Milestone 4** [P-15]: Participate in face to face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 4 [15.1]: Participate in semi-annual face-to-face meetings organized by RHP Data Source: Documentation of meetings. Baseline/Goal: Meetings twice per year Milestone 4 Estimated Incentive	**Milestone 6** [P-15]: Participate in face to face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 6 [15.1]: Participate in semi-annual face-to-face meetings organized by RHP. Data Source: Documentation of meetings. Baseline/Goal: Meetings at least twice per year Milestone 6 Estimated Incentive Payment: $1,017,224 **Milestone 7** [I-13]: Progress toward target/goal. Metric 7 [I-13.1]: Number or percent of all clinical cases that meet target/goal. Data source: Internal reporting systems Baseline/Goal: Serve at least 30% of clinical cases toward target goal. Milestone 7 Estimated Incentive Payment: $1,017,224	**Milestone 9** [P-15]: Participate in face to face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 9 [15.1]: Participate in semi-annual face-to-face meetings organized by RHP Data Source: documentation of meetings. Baseline/Goal: Meetings twice per year Milestone 9 Estimated Incentive Payment: $941,286 **Milestone 10** [I-13]: Progress toward target/goal. Metric 10 [I-13.1]: Number or percent of all clinical cases that meet target/goal. Data source: Internal reporting systems. Baseline/Goal: Serve at least 60% of clinical cases toward target goal. Milestone 10 Estimated Incentive Payment: $941,286

135234606.2.1	***2.8.6***	***2.8.6***	***24 Hour Psychiatric Triage Facility***	
Denton County MHMR Center				*135234606*
Related Category 3 Outcome Measure(s):	*135234606.3.1*	*IT-9.2*	*Right Care, Right Setting: 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)**
Payment: $ 1,302,664	Payment: $868,443 **Milestone 5** [I-13]: Progress toward target/goal. Metric 5 [I-13.1]: Number or percent of all clinical cases that meet. target/goal Data Source: Internal reporting systems Baseline/Goal: Serve at least 5% of clinical cases toward target goal Milestone 5 Estimated Incentive Payment: $868,443		**Milestone 8** [I-14]: Measure efficiency and/or cost. Metric 8 [I-14.1]: Report on the project's efficiency and cost. Data Source: Internal reporting systems Baseline/Goal: Report on efficiency and cost by showing a 10% decrease in cost per patient Milestone 8 Estimated Incentive Payment: $1,017,225	**Milestone 11**[I-14]: Measure efficiency and/or cost. Metric 11 [I-14.1]: Report on the project's efficiency and cost. Data Source: Internal reporting systems Baseline/Goal: Report on efficiency and cost by showing a 10% decrease in cost per patient at 20% increase in program productivity. Milestone 11 Estimated Incentive Payment: $941,285
Year 2 Estimated Milestone Bundle Amount: $2,605,328	**Year 3 Estimated Milestone Bundle Amount:** $2,605,328		**Year 4 Estimated Milestone Bundle Amount:** $3,051,673	**Year 5 Estimated Milestone Bundle Amount:** $2,823,857
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $ 11,090,221				

Project Option 2.15.1 - Integrated Primary and Behavioral Health

Unique Project ID: 135234606.2.2
Performing Provider Name/TPI: Denton County MHMR Center/135234606

Provider: Denton County MHMR Center is a state-funded not for profit outpatient mental health clinic serving as the mental health authority for Denton County. Denton County covers 952.98 square miles, has population of 662, 614, and has a rate of growth of 58% over the last 10 years . Denton County does not have an acute-care safety net hospital.

Interventions: This project will implement an integration of care management functions for individuals with co-morbid chronic diseases, mental illnesses, and/or substance use disorders by collaborative partnership agreements for delivery of primary and behavioral health care management.

Need for the Project: Denton County does not have an acute-care safety net hospital. Denton County MHMR Center has an extensive waiting list. The project is needed to decrease the waiting list, increase access to health care, and decrease emergency department costs.

Target Population: Our target population is individuals experiencing co-morbid behavioral health and primary health concerns. Approximately 90% of our current clients are indigent or Medicaid eligible. We estimate 95-100% of our integrated clinic clients will be Medicaid eligible or indigent. We intend to serve at a minimum 200 individuals in our integrated clinic by the end of DY 5.

Category 2 Expected Patient Benefit: The project benefits the patient by improving access to health care for individuals by helping providing both primary and behavioral health care. The individual will experience optimal health through access to preventative care. The indigent individual will be able to have his/her needs met in one location decreasing his/her need for excessive appointments requiring often unattainable transportation. The benefit to the individual includes seeing at least 200 individuals by the end of DY 5 with an average of 3 services per month per individual.

Category 3 Outcomes: IT 6.1- Our goal is to increase patient satisfaction scores by 50% over baseline in DY 4 and 75 % DY 5.

Project Description

Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.

Goals and Relationship to Regional Goals

The goal for the project includes the integration of care management functions for individuals with co-morbid chronic diseases, mental illness, and/or substance use disorders, by collaborative partnership agreements for delivery of primary and behavioral health care management. This project will meet the goals of the region related to the need to coordinate primary and behavioral health services.

Challenges

The challenges and issues of the performing provider include: limited funding opportunities for expansion, extensive waitlist of behavioral health services, currently over-serving Department of State Health Services (DSHS) funding capacity to fulfill the needs for behavioral health services (adults 113%, children and adolescents 197%), lack of community resources for provision of primary care and co-morbid chronic diseases.

The implementation of this project will reduce the extensive wait list for Denton County MHMR Center (over 300 clients as of October 2012), provide access health care for uninsured and underinsured clients, and reduce Emergency Department (ED) costs by providing improved access. In addition, Denton County does not have a public acute-care safety net hospital. According to 2011 census, Denton County has a poverty level of 8.9%. According to 2011 United Way of Denton County, Inc. needs assessment, 17.2% of adults and 10.6% of children in Denton County are uninsured [CN.5, CN.6].

5-Year Expected Outcome for Provider and Patients

The intended outcome is to improve patient satisfaction for patients who would benefit from integration of primary and behavioral health services and reduce inappropriate ED usage.

Starting Point/Baseline

In Denton County, those that are uninsured, underinsured, or have Medicaid, have limited access to primary care providers and behavioral health providers. These populations often have multiple concomitant issues such as substance use; traumatic injuries; homelessness, cognitive challenges; lack of daily living skills and lack of natural supports. The starting point will be to open a primary/behavioral health clinic two days a week providing services to a target of greater than 12 clients per day. The four year expected outcome of the project is to provide expanded hours of operation and access to primary and behavioral health services for a minimum of 200 individuals. The state's mental health system provides rehabilitative services and pharmacotherapy to people with certain severe mental diagnoses and functional limitations, but can serve only a fraction of the medically indigent population; the system does not serve other high risk behavioral health populations and does not provide the range of

services needed to deal with complex mental and physical needs. These individuals consistently use the emergency rooms for routine or non-emergent health care needs. Indigent health care is limited in Denton County with few resources and no public hospital system [CN.6]. Without access to preventative care, chronic medical and behavioral health needs go untreated and result in increased costs to the individual and the community [5, 6, 11].

Rationale

The Integrated Primary and Behavioral Health facility is a new initiative for Denton County MHMR Center. The rationale for the project is the value to the community, public health system, criminal justice system, and hospitals by reducing inappropriate emergency room admissions, readmissions, and inappropriate use of the criminal justice system. The project will address core components A, B, C, D, E, F, G, H, I, and J of 2.15.1 of the RHP planning protocol. If integrated and primary behavioral health care access is not available, the indigent population is often forced to turn to expensive sites of care such as EDs and urgent care. The United Way of Denton County, Inc. Needs Assessment further identified affordable and accessible health care and preventative health care as needs in Denton County [CN.6]. Research has shown that integrated health care can save billions yearly, by avoiding emergency room visits and incarceration. An example of cost savings is utilizing community based care at the average of $12 per day, compared with the cost of $1256 for a limited emergency room visit. According to the National Association of Community Mental Health Centers Inc. as cited in an article [6], 35% of emergency room visits are avoidable if access to primary care exists, leading to savings of $18 billion per year. This study cites Texas as one of four states that spends over $1 billion annually in ED visits [6]. A different example of the cost effectiveness of integrated health care includes a pilot integrated health care system in Colorado, where a $2040 savings per year per patient occurred. A total of 200 served over five years equal $408,000 saved over regular care [3]. In a project report [2], it is listed that the effect of an integrated intervention is equivalent to an increase of 0.338 quality-adjusted life-years. Twenty individuals served x 0.338 x $50,000 (life year value) = $338,000 savings. Collaborative care models have shown savings of $1.7 for every dollar invested. Integrated primary and behavioral health care has shown improved quality of care, cost effectiveness, and decreases the disparities in health care [1, 3, 6, 7, 8, 9, 10, 11]. In addition, through econometrics, we value the impact of this project to the community at $15,000,000, although Denton County MHMR Center is requesting a much smaller DSRIP valuation/incentive payment for this project.

Project Components

The required core components for Project 2.15.1 - Design, implement, and evaluate projects that provide integrated primary and behavioral health care services include:

a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community. Examples of selection criteria could include proximity/accessibility to target population, physical plant conducive to provider

interaction; ability / willingness to integrate and share data electronically; receptivity to integrated team approach.

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 Electronic health record system or participation in a health information exchange – depending on the size and scope of the local project.
g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.
h) Arrange for utilities and building services for these settings
i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.
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 "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Unique community need identification numbers the project addresses

- CN5 Behavioral Health
- CN6 Behavioral Health and Primary Care

How the project represents a new initiative

This is a new initiative for Denton County MHMR Center

Related Category 3 Outcome Measures

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

Integrated health care patient satisfaction will lead to improved health through easier access to routine health care. Integrated health and preventative care also leads to greater participation and adherence to treatment and prevention recommendations. The priority stems from a lack of resources in this county for low income health care services as evidenced by Denton County MHMR Center's growing wait list for services. Denton County MHMR Center's waiting list for behavioral health services is over 300 as of October 2012. Currently, Denton County has no public hospital and limited resources for indigent care. The individual will experience optimal health through access to preventative care. The indigent individual will be able to have his/her needs met in one location decreasing his/her need for excessive apointments requiring expensive often unattainable transportation. Individuals without insurance often seek services at emergency rooms due to being unable to access services elsewhere. Having this clinic would decrease the need for individuals to seek treatment for preventative care in the EDs. When individuals are more satisfied with services, they are more likely to participate to the fullest extent, leading to a greater likelihood of success.

Relationship to other Projects

Other projects related ot improving behavioral health services include:

135234606.2.1	Establish 24-hour triage
135234606.2.3	Crisis residential center

Related Category 4 Population-focused improvements

RD-4: Patient-centered Care

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

Other performing providers with related projects include:

HCA Medical City Dallas Hospital:	020943901.2.1
Dallas County MHMR dba MetroCare:	137252607.2.1

As appropriate, we plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The value for the project to the community, public health system, criminal justice system, and hospitals is reducing inappropriate emergency room admissions, readmissions, and inappropriate use of the criminal justice system. If integrated and primary behavioral health care access is not available, the indigent population is often forced to turn to expensive sites of care such as EDs and urgent care.

Research shows that integrated health care can save billions yearly, by avoiding emergency room visits and incarceration. The cost of care for a person that has a mental illness is as follows: Incarceration $137 per day, ER $1265 per visit, state mental health hospital $400 per day; verses community cost of care for a person that has a mental illness is $12 per day. According to the National Association of Community Mental Health Centers Inc. as cited in article [6], 35% of emergency room visits are avoidable if access to primary care exists, leading to savings of $18 billion a year. This study cites Texas as one of four states that spends over $1 billion annually in ED visits [6]. A different example of the cost effectiveness of integrated health care includes a pilot integrated health care system in Colorado, where a $2040 saving per year per patient occurred. A total of 200 served over five years equal $408,000 saved over regular care [3]. In a project report, it is listed that the effect of an integrated intervention is equivalent to an increase of 0.338 quality-adjusted life-years [2]. Twenty individuals served x 0.338 x $50,000 (life year value) = $338,000 savings. Collaborative care models have shown savings of $1.7 for every dollar invested. Integrated primary and behavioral health care has shown to improve the quality of care, cost effectiveness, and decreases the disparities in health care [1, 3, 4, 6, 7, 8, 9, 10, 11, 12].

End Notes/References

1. American Hospital Association. (2012). *Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes*. Retrieved from http://http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf

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135234606.2.2	***2.15.1***	***2.15.1 (A-J)***	***INTEGRATE PRIMARY AND BEHAVIORAL HEALTH SERVICES***	
Denton County MHMR Center				*135234606*
Related Category 3 Outcome Measure(s):	*135234606.3.2*	*IT-6.1*	*Patient Satisfaction: Percent improvement over 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)**
Milestone 1 [P-1]: Conduct needs assessment to determine areas of the county where the co-location of services has the potential to benefit a significant number of people who have physical/behavioral health needs. Metric 1 [P-1.1]: Number of patients in various areas who might benefit from integrated services. Demographics, location, and diagnoses. Data Source: Needs assessment/ waiting list. Baseline/Goal: 17.2% of adults and 10.6% of children in various areas of Denton County might benefit from integrated services. Milestone 1 Estimated Incentive Payment: $410,506 Milestone 2 [P-4]: Assess ease of access to potential locations for project implementation. Metric 2 [P-4.1]: Access to major roadways, bus routes, or proximity to a large number of individuals who may benefit from services.	Milestone 4 [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 providers and vice versa. Metric 4 [P-3.1]: Number and types of referrals that are made between providers at the location. Data Source: Surveys of providers to determine the degree and quality of information sharing; review of referral data and survey results. Baseline/Goal: A minimum of 40% of individuals have referrals and information sharing. Milestone 4 Estimated Incentive Payment: $333,890 Milestone 5 [P-10]: 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 5 [10.1]: Participate in semi-annual face-to-face meetings	Milestone 8 [P-10]: 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 8 [10.1]: Participate in semi-annual face-to-face meetings organized by RHP Data Source: Documentation of meetings Baseline/Goal: Meetings twice per year. Milestone 8 Estimated Incentive Payment: $445,187 Milestone 9[I-8]: Integrated services Metric 9 [I-8.1]: X% of individuals receiving both physical and behavioral health care at the established locations. Data source: Project data; claims and encounter data; medical records. Baseline/Goal: 30% of individuals receiving both physical and behavioral health care at the	Milestone 11 [P-10]: 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 11 [P -10.1]: Participate in semi-annual face-to-face meetings organized by RHP Data Source: Documentation of meetings Baseline/Goal: Meetings twice per year. Milestone 11 Estimated Incentive Payment: $445,187 Milestone 12 [I-8]: Integrated services Metric 12 [I-8.1] X% of individuals receiving both physical and behavioral health care at the established locations. Data source: Project data; claims and encounter data; medical records. Baseline/Goal: 50% of individuals receiving both physical and behavioral health care at the established locations.

135234606.2.2	*2.15.1*	*2.15.1 (A-J)*	*INTEGRATE PRIMARY AND BEHAVIORAL HEALTH SERVICES*	
Denton County MHMR Center				*135234606*
Related Category 3 Outcome Measure(s):	*135234606.3.2*	*IT-6.1*	*Patient Satisfaction: Percent improvement over 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)**
Data source: City/County data, maps, demographic data relating to prevalence of health conditions. Baseline/Goal: By the end of DY 2 develop a resource that will identify access to major roadways, bus routes, or proximity to other transportation for individuals that would benefit from services. Milestone 2 Estimated Incentive Payment: $410,506 Milestone 3 [P-10]: 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 3 [P-10.1]: Participate in semi-annual face-to-face meetings organized by RHP Data Source-documentation of meetings Baseline/Goal: Meetings twice per year Milestone 3 Estimated Incentive Payment: $410,507	organized by RHP. Data Source: Documentation of meetings. Baseline/Goal: meetings twice per year. Milestone 5 Estimated Incentive Payment: $333,890 Milestone 6 [I-8]: Integrated services. Metric 6 [I-8.1]: X% of individuals receiving both physical and behavioral health care at the established locations. Data source: Project data, claims and encounter data, medical records. Baseline/Goal: 10% of individuals receiving both physical and behavioral health care at the established locations. Milestone 6 Estimated Incentive Payment: $333,890 Milestone 7 [I-9]: Coordination of Care Metric 7 [I-9.1]: X% of individuals with a treatment plan developed and implemented with primary care and	established locations Milestone 9 Estimated Incentive Payment: $445,187 Milestone 10 [I-9]: Coordination of care. Metric 10[I-9.1] : X% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise. Data Source: Project data Baseline/Goal: 100% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise. Milestone 10 Estimated Incentive Payment: $445,187	Milestone 12 Estimated Incentive Payment: $445,187 Milestone 13 [1-9]: Coordination of care. Metric 13 [I-9]: X% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise. Data Source: Project data Baseline/Goal: 100% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise. Milestone 13 Estimated Incentive Payment: $445,187

135234606.2.2	*2.15.1*	*2.15.1 (A-J)*	*INTEGRATE PRIMARY AND BEHAVIORAL HEALTH SERVICES*	
Denton County MHMR Center				*135234606*
Related Category 3 Outcome Measure(s):	*135234606.3.2*	*IT-6.1*	*Patient Satisfaction: Percent improvement over 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)**
	behavioral health expertise. Data Source: Project data Baseline/Goal: 100% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise. Milestone 7 Estimated Incentive Payment: $333,891			
Year 2 Estimated Milestone Bundle Amount (add incentive payment amounts from each milestone): $1,231,519	**Year 3 Estimated Milestone Bundle Amount:** $1,335,561		**Year 4 Estimated Milestone Bundle Amount:** $1,335,561	**Year 5 Estimated Milestone Bundle Amount:** $1,335,561
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $ 5,238,202				

Project Option 2.13.1 - Crisis Residential Care

Unique Project ID: 135234606.2.3
Performing Provider Name/TPI: Denton County MHMR Center/135234606

Provider: Denton County MHMR Center is a state-funded not for profit outpatient mental health clinic serving as the mental health authority for Denton County. Denton County covers 952.98 square miles ,has population of 662, 614, and has a rate of growth of 58% over the last 10 years . Denton County does not have an acute-care safety net hospital.

Interventions: This project will implement a crisis residential care program to provide interventions for a targeted population to prevent unnecessary use of services in specific settings.

Need for the Project: Denton County has limited resources for housing and shelter. Our Section 8 housing program has an extensive waiting list and is currently closed. Denton County does not have an acute-care safety net hospital. This project will help individuals who do not have adequate shelter to not inappropriately access hospitals and the criminal justice systems.

Target Population: Our target population is individuals with a severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. Factors could include chronic physical health conditions, chronic or intermittent homelessness, cognitive issues, resulting from severe mental illness and/or forensic involvement. Approximately 90% of our current clients are indigent or Medicaid eligible and we estimate that 95-100% of our residential facility clients will be indigent or Medicaid eligible. We intend to serve individuals with at a minimum 2,000 residential bed days at the residential facility by the end of DY 5.

Category 2 Expected Patient Benefit: The benefit to the client is improved functional status for individuals in the program as measured by standardized instruments. By the end of DY 5, this project plans to provide a minimum of 2,000 residential bed days to individuals in psychiatric crisis. We anticipate the volume of services to be a minimum of 2 per bed day.

Category 3 Outcomes: IT 6.1- Our goal is to increase patient satisfaction scores by 50% over baseline in DY 4 and 75% in DY 5.

Project Description
Establish a crisis residential care program to provide an intervention for a target behavioral health population to prevent unnecessary use of services in a specified setting. Increase the capacity to provide crisis residential services to better accommodate the high demand for crisis residential services and reduce potentially preventable admissions and readmissions to hospitals and jails.

Goals and Relationship to Regional Goals

The goal for this project is to reduce the demand for inappropriate admissions (i.e., the criminal justice system, ER, urgent care) and assist the individual in maintaining residence in the community. The community need for the project is due to readmissions for inpatient care. This project will meet the goals of the region by decreasing inappropriate inpatient admissions and incarcerations.

Challenges

The challenges and issues of the performing provider include funding for project, lack of community resources for crisis residential services, and the lack of a public acute-care safety net hospital in Denton County. According to the 2011 United Way Needs Survey, emergency shelter and transitional housing needs have continued to rise in Denton County [CN.5, CN.7]. The Section 8 Denton Housing Authority (DHA) list closed in June of 2011. The DHA currently has a waitlist of 2,700 individuals; the estimated wait for assistance is four years.

The starting point would be the development of a crisis residential home with a capacity of 8 individuals with additional beds for additional needs, such as individuals with substance abuse disorders, transition from criminal justice system, and transition from a higher level of need. The four year expected outcome of the project is to provide short-term community based residential crisis treatment for individuals in Denton County.

5-Year Expected Outcome for Provider and Patients

The combination of these services will reduce behavioral and medical emergency room admission and readmission as well as decrease lost revenue and decrease avoidable incarceration.

Starting Point/Baseline

In Denton County, those that are uninsured or underinsured have limited access to shelter and stabilization services. Denton County has the least amount of mental health funding per capita in the state of Texas. The emergency rooms, law enforcement, and the criminal justice system have an increased burden due to this lack of funding and resources. Current access to emergency crisis services is available by calling the access/crisis line. Denton County does not have an acute-care safety net hospital. In addition, Denton County lacks resources for homeless individuals. The starting point of this project is to set up a residential facility to treat individuals with behavioral health diagnoses to keep them from potentially admitting and/or readmitting into the hospital. Our four year outcome is to expand on our initial project to serve more individuals in our residential facility.

Rationale

The Crisis Residental project is a new initiative for Denton County MHMR Center. The goal of this project is to improve outcomes and promote access to quality behavioral health care services on a regular basis. The project will include the core components A, B, C, D, and E of 2.13.1 in the RHP planning protocol.

The project has been identified as a need in Denton County in the 2011 United Way Needs Assessment Survey [10]. Emergency shelter and transitional housing have been included in the top four needs in the income section of this community needs assessment [10, 11, CN.5]. Individuals that have a mental health diagnosis and are in need of housing services often turn to the emergency rooms as first line treatment for their mental illness and housing needs. This treatment center will provide emergency and transitional housing and shelter using the Department of State Health Services crisis residential staffing guidelines. Qualified mental health professionals will be available. The combination of these services will reduce behavioral and medical emergency room admission and readmission, as well as decrease lost revenue and increase expenditure on avoidable incarceration. Acute treatment costs were 44% lower in a crisis residential program ($3046 per episode) as compared to hospitalization ($5,549 per episode) and the typical cost for homeless individuals is $2,897 per month [1]. Typical cost of housing for residents in supportive housing is $605 per month. This is a savings of $2,292 a month for one individual [2, 3, 4, 5, 6, 7, 8, 9]. In addition, through econometrics, we value the impact of this project to the community at $15,000,000 although Denton County MHMR is requesting a smaller DSRIP valuation/incentive payment for this project.

Project Components

The require core components of Project 2.13.1 - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population include:

a. Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement.
b. Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.

c. Develop project evaluation plan using qualitative/quantitative metrics to determine outcomes
d. Design models which include an appropriate range of community-based services and residential supports.
e. Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Examples of data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); medical, prescription drug and claims/encounter records; participant surveys; provider surveys. Identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient populations, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations

Reasons/Rational for selecting outcome measures

Satisfaction surveys measure the perception of services rendered. Crisis residential patient satisfaction will lead to improved health by decreasing inpatient stays and leading client to improved success in community settings. The priority stems from a lack of resources in this county for residential services for clients with behavioral health and substance abuse disorders.

Specify unique community need identification numbers the project addresses

- CN5 Behavioral Health
- CN7 Behavioral Health and Jail Population

How the project represents a new initiative

This project is a new initiative to establish a crisis residential care program which Denton County currently does not have available for the needs of this targeted population.

Related Category 3 Outcome Measures

IT-6.1 Percent over baseline improvement of patient satisfaction scores

Satisfaction surveys measure the perception of services rendered. Crisis residential patient satisfaction will lead to improved health by decreasing inpatient stays and leading client to improved success in community settings. The priority stems from a lack of resources in this county for residential services for clients with behavioral health and substance abuse disorders. When an individual is satisfied with the services he/she is receiving, the chances of successfully completing the program are greater. Succcess in the crisis residential program can help

individuals avoid jail, EDs, and long term homelessness. The program is designed to allow indiviudals to be in the county with which they are familiar to receive treatment.

Relationship to other Projects

Other projects related to improving behavioral health services include:

135234606.2.1	Establish 24-hour triage
135234606.2.2	Integrate primary and behavioral health services

Related Category 4 Population-focused improvements

RD-4: Patient-centered healthcare

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

NA (What other Performing Provider Projects address preventable admissions/readmissions and reduced incarcerations?)

As appropriate, we plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The value of this project is to improve outcomes and promote access to quality behavioral health care services on a regular basis. The project has been identified as a need in Denton County in the United Way Needs Assessment Survey [10, CN.5]. Emergency shelter and transitional housing have been included in the top four needs in the income section of this community needs assessment [10, 11, CN.5]. Individuals that have a mental health diagnosis and are in need of housing services often turn to the emergency rooms as first line treatment for their mental illness and housing needs. The crisis residential treatment center will provide emergency and transitional housing and shelter utilizing Department of Social and Health Services crisis residential staffing guidelines. Qualified mental health professionals will be available. The combination of these services will reduce behavioral and medical emergency room admission and readmission, as well as decrease lost revenue and increase expenditure on avoidable incarceration. Acute treatment costs were 44% lower in a crisis residential program ($3046 per episode) as compared to hospitalization ($5,549 per episode) and the typical cost for homeless persons is $2,897 per month [1]. The typical cost of housing for residents in supportive housing is $605 per month. This is a savings of $2,292 a month for one individual [2, 3, 4, 5, 6, 7, 8, 9].

End Notes/References

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8. Stone, J. & Hoffman, G. (2010). *Medicare hospital readmissions: Issues, policy options and PACA.* Retrieved from http://www.hospitalmedicine.org/AM/pdf/advocacy/CRS_Readmissions_Report.df

9. Texas Council of Community Mental Health and Mental Retardation. Current pamphlet. *Building strong communities one person at a time*. Retrieved from http://www.txcouncil.com

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135234606.2.3	***2.13.1***	***2.13.1 (A-E)***	*Crisis Residential Care*	
Denton County MHMR Center				*135234606*
Related Category 3 Outcome Measure(s):	*135234606.3.3*	*IT-6.1*	*Patient Satisfaction: Percentage improvement over 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)**
Milestone 1 [P-7]: Participate in face to face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings organized by RHP Data Source: Documentation of meetings Baseline/Goal: Meeting twice per year. Milestone 1 Estimated Incentive Payment: *$1,013,800* Milestone 2 [P-1]: Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources. Metric 2 [P-1.1] Number of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, and ED utilization. Data Source: Project Documentation Baseline/Goal: Conduct needs		Milestone 3 [P-3]: Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities). Metric 3 [P-3.1]: Number of targeted individuals enrolled/served in the project. Data Source: Project documentation. Baseline/Goal: Targeted individuals enrolled/served in the project served in 75 residential beds. Milestone 3 Estimated Incentive Payment: $742,533 Milestone 4 [P-7]: Participate in face to face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 4 [7.1]: Participate in semi-annual face-to-face meetings	Milestone 6 [P-3]: Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities). Metric 6 [P-3.1]: Number of targeted individuals enrolled/served in the project. Data Source: Project documentation. Baseline/Goal: Targeted individuals enrolled/served in the project served in 600 residential beds. Milestone 6 Estimated Incentive Payment: $742,533 Milestone 7 [P-7]: Participate in face to face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.	**Milestone 9** [P-3]: Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities). Metric 9 [P-3.1]: Number of targeted individuals enrolled/served in the project. Data Source: Project documentation Baseline/Goal: Targeted individuals enrolled/served in the project served in 1000 residential beds. Milestone 9 Estimated Incentive Payment: $ 556,900 Milestone 10 [P-7]: Participate in face to face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 10 [7.1]: Participate in semi-annual face-to-face meetings organized

135234606.2.3	*2.13.1*	*2.13.1 (A-E)*	*Crisis Residential Care*	
Denton County MHMR Center				*135234606*
Related Category 3 Outcome Measure(s):	*135234606.3.3*	*IT-6.1*	*Patient Satisfaction: Percentage improvement over 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)**
assessment with minimum of 200 individuals and collect demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, and ED utilization. Milestone 2 Estimated Incentive Payment: $1,013,800	organized by RHP. Data Source: Documentation of meetings. Baseline/Goal: Meetings twice per year Milestone 4 Estimated Incentive Payment: $742,533 Milestone 5 [I-5]: Functional status. Metric 5 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.). Data Source: Project documentation Baseline/Goal: 15% of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.). Estimated Incentive Payment: $742,534		Metric 7 [7.1]: Participate in semi-annual face-to-face meetings organized by RHP Data Source: Documentation of meetings. Baseline/Goal: Meetings twice per year Milestone 7 Estimated Incentive Payment: $742,533 Milestone 8 [I-5]: Functional status. Metric 8 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) **Data Source:** Project documentation Baseline/Goal: 25% of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) Milestone 8 Estimated Incentive Payment: $742,534	by RHP Data Source: Documentation of meetings. Baseline/Goal: Meetings twice per year Milestone 10 Estimated Incentive Payment: $ 556,900 Milestone 11 [I-5]: Functional status. Metric 11 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. (e.g. ANSA, CANS, etc.) Data Source: Project documentation Baseline/Goal: 50% of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.) Milestone 11 Estimated Incentive Payment: $ 556,900 Milestone 12 [I-1]: Criminal justice admissions/readmissions. Metric 12 [I-1.1]: X% decrease in preventable admissions and

135234606.2.3	***2.13.1***	***2.13.1 (A-E)***	*Crisis Residential Care*	
Denton County MHMR Center				*135234606*
Related Category 3 Outcome Measure(s):	*135234606.3.3*	*IT-6.1*	*Patient Satisfaction: Percentage improvement over 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)**
				readmissions into criminal justice system. Data Source: Project documentation Milestone 12 Estimated Incentive Payment: $ 556,900
Year 2 Estimated Milestone Bundle Amount: $ 2,027,600	**Year 3 Estimated Milestone Bundle Amount:** $ 2,227,600		**Year 4 Estimated Milestone Bundle Amount:** $ 2,227,600	**Year 5 Estimated Milestone Bundle Amount:** $ 2,227,600
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $ 8,710,400				

Project Option 2.8.11 - Implement an Innovative and Evidence Based Intervention that will lead to reduction in Sepsis Complications (Apply Process Improvement Methodology to Improve Quality/Efficiency)

Unique Project ID: 111905902.2.1
Performing Provider Name/TPI: Denton Regional Medical Center/111905902

Provider: Denton Regional Medical Center is a 179-bed acute care hospital in Denton County, Texas serving a primary and secondary service population of approximately 430,000.

Intervention(s): This project will implement process improvement methodologies in a sepsis evidenced based care program to reduce sepsis complications. Interventions will include implementing houseiwde 12/hour screenings on all patients, ED protocols, ICU Sepsis evidence based care treatment protocols and developing a measurement and reporitng system.

Need for the project: The current diagnosis and treatment of sepsis is not adequate for patient safety and quality of care with mortality as high as 60%. Complications from lack of timely and appropriate treatment of sepsis including lifetime health issues, disability and mortality put an unnecessary burden on society and the healthcare system. Process improvement methodologies will facilitate analysis of the evidence based program and implementation of corrective actions to improve implementation and maximize outcomes.

Target population: The target population for diagnosing sepsis arepatients presenting to ED and all patients in house. . By initiating housewide screening every 12 hours on patients , we believe the number of patients diagnosed will increase. Once diagnosed with sepsis hock, severe sepsis, evidence based treatment is necessary Approximately 28% of patients to be screened are Medicaid and indigent. It is estimated currently 23% of our patients treated for sepsis are Medicaid eligible or indigent. Based on current processes over 275 patients will be treated over course of the waiver, however with improvement in diagnosis a key element of the program, this number is expected to increase to estimated 530 patients over 5 years (DY1-55,DY2-83,DY3-103,DY-129,DY5-160) Patients who are Medicaid eligible or uninsured will benefit as they more often use the ED and their illness is farther progressed when presenting to ED along with greater complexity of co-morbid diseases. Due to lack of access to medical care patients tend to delay seeking care which can lead to harmful results. The quicker diagnosis of sepsis and evidence-based care will prevent greater mortality and disability from sepsis.

Category 1 or 2 expected patient benefits: The project seeks to increase the timeliness of correctly diagnosing sepsis in order the begin evidence based care with improved the compliance with Sepsis Bundle and Resuscitation for patients diagnosed with severe sepsis and septic shock. We expect to diagnose and treat 530 sepsis patients (estimated at DY 1- 55, DY2-83, DY 3- 103, DY 4- 129, DY 5-160). 55 patients were diagnosed in DY 1 with the implementation of the sepsis program. However only 38 patients were properly treated with

the evidence based care plan from the program. In addition it is estimated based on similar size hospitals with sepsis programs, we should expect to diagnosis 159 patients a year. Potentially we are not properly diagnosing 104 patients a year. Patients that may not diagnosed/diagnosed timely or not receive evidence based treatment may have resulted in death or disability. The program will have great benefit to patients to reduce harm from lack of proper and timely diagnosis and/or lack of evidence based treatment.

Category 3 Outcomes:
IT-4.8 Our goal is to reduce the Sepsis Mortality of patients diagnosed with sepsis from 30% currently to 20% by DY5. The estimated DY 1 mortality was 31% and improvement of 25% by DY 5, morality would be 23%.
IT -4.9 Our goal is the reduce the Average length of stay of patients with sepsis by 10% in DY 4 and 15 % in DY 5. Estimated DY 1 ALOS was 10.1 , a reduction goal by DY 5 of 2 days to ALOS of 8.10.

Project Description
The project will design and implement a **Process Improvement** plan to increase the utilization and compliance with Sepsis Resuscitation and Management Bundles to improve patient outcomes.

Denton Regional Medical Center is committed to continuous quality improvement so all of our patients receive the safest and highest quality health care possible. We are implementing a standardized, evidence-based program for early detection and resuscitation of patients with severe sepsis and septic shock to reduce unnecessary death and harm attributable to sepsis. Our processes and interventions are based upon evidence-based care models, which include a sepsis resuscitation bundle for Emergency Department (ED) patients and a sepsis management bundle for ongoing care. Rapid diagnosis and management are cornerstones to successful outcomes.

The ICU and ED plans for improvements in sepsis identification and treatment includes, revising the electronic nurse sepsis screening at triage, implementing an electronic nurse sepsis screen to aid in early detection of inpatients, staff education regarding sepsis screening, and refining the Rapid Response Team (RRT) processes to include sepsis screening and initial resuscitation. This allows the RRT to begin fluid resuscitation on the in-house patient that screens positive for severe sepsis or septic shock and is hypotensive.

Denton Regional Medical Center will also track primary endpoints of mortality and ICU LOS. Process and other measures will be tracked that include, percentage of patients initiated on vasopressors and mean days of vasopressor use, percentage of patients initiated on the mechanical ventilator and mean ventilator days, and initiation of hemodialysis or continuous renal replacement therapy.

Our target population is any patient diagnosis of severe sepsis, septic shock, and/or lactate >4mmol/L (36mg/dl).

Although great work has been done to implement protocols and interventions, utilization and compliance of Sepsis Resuscitations and Management Bundles still remains a challenge. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through multidisciplinary teams.

Goals and Relationship to Regional Goals:

The goal of this project is to implement a Process Improvement plan to improve safety and quality for those patients with Sepsis. We will:

1. Achieve 90% Compliance with the Sepsis Resuscitation and Management Bundles in patients admitted to the ICU.
2. Substantially improve early sepsis identification, reduce sepsis related Mortality by 25% from baseline.
3. Effective and fully implemented measurement and reporting system supporting compliance with the Sepsis Resuscitation and Management Bundles.
4. Continue to work with Emergency Medical Services to improve the delivery of care provided to patients with suspected infection.
5. Improve identification of sepsis patients' house wide by implementing nursing admission screening and shift assessments for sepsis screening.
6. Improve identification of sepsis, compliance from TBD with current Sepsis Resuscitation and Management Bundles in the Emergency Department.

This project supports the regional goals to improve the patient care experience, health outcomes for the population and the per capita cost of care. Specifically, this project will improve the early diagnosis of patients with severe sepsis and septic shock so that evidence based care can be delivered. Improved recovery of patients with severe sepsis and septic shock will reduce unnecessary death and harm and reduce cost of post hospital care in addition to quality-adjusted life gained.

Challenges

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. The eighth leading cause of death is influenza and pneumonia combined, and pneumonia is a leading source of severe sepsis and septic shock. Septicemia, influenza, and pneumonia deaths in 2007 contributed to over 80,000 deaths. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. In the United States, there are approximately 750,000 new cases of sepsis, which includes diagnoses of severe sepsis and septic shock, each year, and mortality from severe

sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Proactive analysis of the contributing factors contributing to the design of evidenced based standardized care sets and subsequent adoption of those tools will aid greatly to reducing variation and associated cost. Early recognition and management of sepsis results in lives saved.

5-Year Expected Outcome for Provider and Patients

We expect to reach 100% compliance in identification/diagnosing of patients with severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl). We also expect to be 90% compliance with application of the Sepsis Bundles for patients that meet specified criteria.

Starting Point/Baseline

The number of patients with severe sepsis, septic shock and/or lactate>4mmol/L (36mg/dl) that would qualify for sepsis resuscitation and management bundles based on expected sepsis claims from similar size hospital and mature sepsis programs would be 159 per year for a total of 530 patient over course of the waiver (DY1-55,DY2-83, DY3-103, DY4-129, DY5-160). The hospital only diagnosed 55 patients in DY 1. Of those patients diagnosed only 38 received evidenced based care for sepsis bundles. Active implementation of sepsis resuscitation and management bundles and data collection is beginning in 2012. Early data collection indicates compliance with sepsis bundles is a low as 50%. It is expected that the morality rate for this population in DY 2 will initially increase compared to DY 1 due to more patients being correctly diagnosed with new sepsis protocols thus a baseline will be established in DY2 to measure same mortality based on same standards of care. The same is true for average length of stay, although it may decrease rather tha increase. A baseline in DY 2 is necessary to measure patients receiving the same protocol based diagnosis and standard of care.

Rationale

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. The eighth leading cause of death is influenza and pneumonia combined, and pneumonia is a leading source of severe sepsis and septic shock. Septicemia, influenza, and pneumonia deaths in 2007 contributed to over 80,000 deaths. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. In the United States, there are approximately 750,000 new cases of sepsis, which includes diagnoses of severe sepsis and septic shock, each year, and mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Project Options

Our internal data shows a mortality rate as high as 60%. Identification and treatment protocols have been developed and implemented to impact mortality and ICU LOS which has improved.

Although program components have been implemented and put in place, we still face the challenge of successful implementation. Also, additional interventions will be implemented in the future (shift assessments on all in-house patients, etc.). To be successful we need to work on processes that create time delays, non-adherence to order set and, failure to identify/diagnose sepsis. We are at 50% compliance in implementing Sepsis Bundles. We believe in order to continue to see improvement from initial implementation, continuous quality improvement through data collection, analysis and review will accelerate change through our multidisciplinary teams.

Project Components

The project components to report metrics for Sepsis Mortality and Average Length of Stay are necessary to measure the success of implementing the Sepsis Improvement Plan.
A Sepsis Improvement Plan must have key elements to be successful. A project plan is necessary to identify and engage all stakeholders (ED, Inpatient Units, and EMS etc), understand current status, resources, baselines, roles and responsibilities, expectations of individuals and outcomes. In order to have an impact on reduction in mortality and average length of stay compliance with Sepsis diagnosis and protocols for Sepsis Bundles are critical. In implementation of a plan, it is necessary to examine the plan as it is implemented, understand what is working and what is not, identify barriers and make corrective action. Continuous quality improvement (CQI) activities will be conducted to ensure successful implementation. In DY2 and DY 3, milestones to implement a program to improve efficiencies and/or reduce program variation are essential to the success of sepsis program. The practice strategy for PDSA and CQI will be a Lean Six Sigma DMAIC approach. A Value Stream Mapping will allow us to document the current state of the program implemented in 2012. The Value Stream Mapping and metric results will determine where variation exits and which processes are constraints to the success of the program. This will help us identify the priority for processes improvement events to be conducted. The team will conduct events utilizing tools to find root causes of variations or process delays. Changes will be implemented with appropriate tools to update the program process. To sustain results of changes implemented, audits at 6 months and 12 months will be utilized for each process improvement event. Each year a Value Stream Mapping can be utilized to validate change, document current state and continue the cycle of process improvement.

Unique Community Need Identification Numbers the Project Addresses

This project addresses identification number CN.11 Patient Safety and Quality from the community needs assessment. The program will improve the health outcomes for patients diagnosed with severe sepsis or sepsis shock.

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

Sepsis Resuscitation and Management Bundle program was kicked off in 2012 as a hospital specific program. Applying process improvement methodologies to the Sepsis program will greatly enhance the chances of being success in implementing the plan and seeing reductions in mortality and average length of stay for improved health outcomes.

Related Category 3 Outcome Measure(s):

- IT-4.8 Sepsis mortality
- IT-4.9 Average length of stay

Applying process improvement methodologies to Sepsis programs greatly enhances chances of being successful in implementing the plan and seeing reduction in mortality and average length of stay.

We are implementing a standardized, evidence-based program for early detection and resuscitation of patients with severe sepsis and septic shock to reduce unnecessary death and harm attributable to sepsis: Institute for Healthcare Improvement; Surviving Sepsis Campaign; Society of Critical Care Medicine; IDSA Guidelines for appropriate antibiotic selection. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through multidisciplinary teams.

Relationship to other projects

This project supports the population focused improvements 111905902.4.4 RD-3 Potentially Preventable Complications (PPCs) and 111905902.4.6 RD- 5 Emergency Department. Improved quality with evidence based care for sepsis increases education, training, and screening that will reduce preventable complications in the hospital setting and ED care and treatment decisions.

Related Category 4 Population-focused improvements

- RD-3: Potentially Preventable Complications
- RD-5: Emergency Department

Relationship to other Performing Providers and Plan for Learning Collaborative

Related projects (Sepsis Resuscitation and Management improvement) include 020943901.2.3 (Medical City Dallas), 094192402.2.2 (Medical Center of Lewisville) and 127295703.2.6 (Parkland Health & Hospital System)

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared

learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology: . Denton Regional Medical Center defined the population that will be directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The population expected to be positively impacted by the project for mortality was 531 which was determined based on outcome target for reduction in mortality by 25% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 25. The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $258,375 for 5 years.
The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay of 2 days from baseline average of 10 days per patient. This was estimated at total of reduced in patient days by DY 5 of 704. The estimated cost per day for a sepsis patient is $1,049. This totaled approximately $739,230.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $258,375.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 1. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $110,885.

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of mortality reduction at $258,375.
To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $107,551.

The total value of the project then was estimated at $1,732,791. Approximately 79% of the total value was assigned to Category 2 project ($1,370,117)and the remaining 10.46% of value

assigned to Category 3 outcome for Sepsis Mortality ($181,338) and 10.46% assigned to Category 3 outcome for reduced Average Length of Stay ($181,336).

Rationale/Justification: The outcome improvement targets are dependent on the target population served (sepsis patients have increased rates of mortality), size, and also current processes in place that already treat Sepsis.

Community benefits were calculated using the following factors: lost productivity (net of lost wages), worker presenteeism, lost in payroll taxes and lost sales tax. Individual benefits were calculated using the following factors: lost wages, caretaker expense and extension of life (if applicable).

The economic value of each targeted improvement outcome from evidence based studies was used a guide for the overall value of project. Additional value was considered for resource investments needed, timelines, and risk and project scope.

111905902.2.1	*2.8.11*	***NA***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE BASED INTERVENTION THAT WILL LEAD TO REDUCTION IN SEPSIS COMPLICATIONS***	
Denton Regional Medical Center				*111905902*
Related Category 3 Outcome Measure(s):	*111905902.3.1* *111905902.3.2*	*3 IT-4.8* *3 IT-4.9*	*Sepsis Mortality* *Average Length of Stay*	
Year 2 (10/1/2012 – 9/30/2013)		**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 re-design Metric 1 [P-X.1]: Documentation of Sepsis Improvement Plan Baseline/Goal: Plan Data Source: Plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $85,191 **Milestone 2** [P-6.]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events Baseline/Goal: Implement events Data Source: Plan Milestone 2 Estimated Incentive Payment *(maximum amount):* $85,191 **Milestone 3** [P-X]: Participate in a learning collaborative		**Milestone 5** [P-6]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events (Documentation of all steps conducted in the PDSA) Baseline/Goal: Develop a sepsis improvement plan Data Source: Plan Milestone 5 Estimated Incentive Payment: $116,174 **Milestone 6** [I-13.1]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1]: Number or percent of all clinical cases that meet target/goal Goal: Improve compliance from 50% above baseline, 52 cases on bundle Data Source: EHR	**Milestone 8** [I-13]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1] Number or percent of all clinical cases that meet target/goal Goal: Improve compliance from 70% above baseline, 90 cases on bundle Data Source: EHR Milestone 8 Estimated Incentive Payment: $186,418 **Milestone 9** [I-13]: Progress toward target/goal (Compliance with correct timely diagnosis of Sepsis) Metric 1 [I-13.1.2]:Number or percent of all clinical cases that meet target/goal Goal: Improve Sepsis Diagnosis Compliance 134% above baseline, cases 129 Data Source: EHR	**Milestone 10** [I-13]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1]: Number or percent of all clinical cases that meet target/goal Goal : Improve compliance from 90% above baseline, 145 cases on bundle Data Source: EHR Milestone 10 Estimated Incentive Payment: $153,997 **Milestone 11** [I-13]: Progress toward target/goal (Compliance with correct timely diagnosis of Sepsis) Metric 1 [I-13.1.2]:Number or percent of all clinical cases that meet target/goal Goal : Improve Sepsis Diagnosis Compliance cases 160 , 193 % over baselineData Source: EHR Milestone 11 Estimated Incentive Payment: $153,997

111905902.2.1	*2.8.11*	***NA***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE BASED INTERVENTION THAT WILL LEAD TO REDUCTION IN SEPSIS COMPLICATIONS***	
Denton Regional Medical Center				*111905902*
Related Category 3 Outcome Measure(s):	*111905902.3.1* *111905902.3.2*	*3 IT-4.8* *3 IT-4.9*	*Sepsis Mortality* *Average Length of Stay*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 1 [P-X.1]: Submit report for Sepsis Improvement Plan findings Baseline/Goal: Annual conference Data source: Conference meeting attendance and minutes Milestone 3 Estimated Incentive Payment *(maximum amount):* $85,191 **Milestone 4** [P-X]: Establish baseline, in order to measure improvement over self (for correct timely diagnosis of sepsis and bundle compliance) Metric 1 [P-X]: Conduct assessment of targeted population Baseline/Goal: Percent compliance with correct timely diagnosis of sepsis Data source: EHR Metric 2 [P-X]: Conduct assessment of targeted population Baseline/Goal: 2011 Sepsis Bundle compliance 3% Data source :EHR Milestone 4 Estimated Incentive Payment *(maximum amount):* $85,191	Milestone 6 Estimated Incentive Payment: $116,175 **Milestone 7** [I-13]: Progress toward target/goal (Compliance with correct timely diagnosis of Sepsis) Metric 1 [I-13.1.2]: Number or percent of all clinical cases that meet target/goal Goal: Improve Sepsis Diagnosis Compliance 103 cases, 97% over baseline Data Source: EHR Milestone 7 Estimated Incentive Payment: $116,175		Milestone 9 Estimated Incentive Payment: $186,417	
Year 2 Estimated Milestone Bundle	Year 3 Estimated Milestone Bundle		Year 4 Estimated Milestone Bundle	Year 5 Estimated Milestone Bundle

111905902.2.1	*2.8.11*	***NA***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE BASED INTERVENTION THAT WILL LEAD TO REDUCTION IN SEPSIS COMPLICATIONS***
Denton Regional Medical Center			*111905902*
Related Category 3 Outcome Measure(s):	*111905902.3.1* *111905902.3.2*	*3 IT-4.8* *3 IT-4.9*	*Sepsis Mortality* *Average Length of Stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Amount: $340,764	Amount: $348,524	Amount: $372,835	Amount: $307,994

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $1,370,117

Project Option 2.4.1 - Implement a strategic improvement program for patient satisfaction (Redesign to Improve Patient Experience)

Unique Project ID: 111905902.2.2
Performing Provider/TPI: Denton Regional Medical Center/111905902

Provider: Denton Regional Medical Center is a 179-bed acute care hospital in Denton County, Texas serving a primary and secondary service population of approximately 430,000.

Intervention(s): This project will create workgroups under a steering committee to implement improvement work on patient experience targets. The goal is to have multiple process improvement events each year from DY 3 through DY 5, at least 2 per year to streamline processes that are not resulting in optimal patient experiences as part of continuous quality improvement. At DY 4 and DY 5, we have routine, formalize updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families with organizational displays. We expect in DY 4 there are 10 such updates and DY 5, 15 updates.

Need for the project: We currently are below the 75% percentile in Grand Composite Scores for HCAHPS survey. Key scores are include communication with nurses and doctor and communication regarding medications. Effective communication is critical for patient safety and quality of care of patients. Improvement efforts have not made material improvement in score in past 4 quarters.

Target population: The target population is IP, ED and OP patients at the hospital. Approximately 33% of our patients are either Medicaid eligible or indigent. We estimate 10,200 patients a year or 54,000 over the course of the waiver will be impacted. We do actively survey 100 patients a month/1200 a year

Category 1 or 2 expected patient benefits: The project seeks to improvement in patient satisfaction scores as measured by HCAHPS Grand Composite Scores. This will be a benefit to patients from better communication with nurses and doctors , better medication management, pain management and discharge planning. Studies have shown with improved patient experience, the quality of care patients experience also improves. This will result in reduce preventable complications such as infections, less readmissions and reduced medication errors. It is estimated patients impacted will be DY1-10,224, DY 2-10,531, DY 3-10,847, DY 4-11,172, DY5-11,507.

Category 3 outcomes: IT-6.1. Our goal is to improve Percent Improvement over baseline of patient satisfaction scores from 69% currently to 82% by DY5, for a 20% improvement.

Project Description

Denton Regional Medical Center is proposing a project to establish baseline is proposing a project to establish baseline Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey scores and implement a patient/family experience strategic plan. A steering committee will be formed and workgroups of the committee will work on process improvements for patient experience targets. Evaluation will be performed and documented to measure implementation progress, results and make adjustments to improvement plans. As part of the strategic plan, patient experience will be an integral part of employee orientation. . A communication plan on work being done to improve the patient experience will be developed and implemented to ensure all employees and physicians are included on progress and initiatives. Studies have shown that improved patient experience can improve patient health outcome and quality.

Goals and Relationship to Regional Goals:

The goal of the project is to implement process improvement plans that target specific patient experiences. The purpose of performing this project is the engage all stakeholder such as leader and employees that can be the high level role to drive the patient experience improvement across the hospital for a cultural change at the organizational level

A major goal of the region is to pursue the triple aim of healthcare by improving patient experience of care, improve health of populations and reduce the cost of healthcare. Redesigning the patient experience at the in the region will impact the health of our community by keeping patients engaged in the healthcare system.

Challenges

The hospital has been participating in HCAHPS to measure patient experience in the hospital setting. Implemented strategies and training plans have not significantly improved scores. Denton Regional Medical Center has achieved Grand Composite score of 69% for 2010 Q3-2011 Q2 and 69% for 2010 Q4-2011Q3, which is consistently been below the CMS National Average. The scores summarize:

- how well nurses and doctors communicate with patients
- how responsive hospital staff are to patients' needs
- how well hospital staff help patients manage pain
- how well the staff communicates with patients about medicines, and whether key information is provided at discharge
- cleanliness and quietness of patients' rooms
- patients' overall rating of the hospital and whether patients' would recommend the hospital to family and friends

The project will address targeted patient experiences with that have not been improved by other initiatives.

5-Year Expected Outcome for Provider and Patients

We expected at end of waiver period we will be > 75th percentile on Grand Composite scores for CMS HCAHPS. The hospital will have improved processes for service that will increase quality and safety of care.

Starting Point/Baseline

Denton Regional Medical Center has achieved Grand Composite scores of 69% in 2010 Q3-2011 Q2 and 69% 2010 Q4-2011 Q3, which has consistently been below the CMS National Average.

Rationale

Patient experience scores are measured internally and reported quarterly from a Gallup Survey. These scores are shared with senior leaders and staff in various manners including Dashboards and reports. Various committees work on departmental and process issues but a coordinated, system wide approach is lacking. A patient/family experience strategic plan will eliminate duplication of time and effort and provide a roadmap for improvement and best practice. Engaging patients and families in the process will strengthen the organization's resolve to get better and stay better. The overall approach to redesigning patient experience will be centered on cultural change at the organizational level. This will involve clinicians, patients and their families or caregivers. An organizational strategy will be developed so that we manage patient experience and create avenues to implement the strategic plan/vision. This project option is best for organizational integration which is critical to successful patient experiences.

Project Components

All core components will be implemented:

a) Organizational integration and prioritization of patient experience
b) Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience;
c) Implementing processes to improve patient's experience in getting through to the clinical practice;
d) Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures.

Establishing a steering committee with high level leadership is necessary to drive cultural change to impact patient experiences. A communication plan will be developed to inform all employees and physicians of the work of the steering committee and results to better integrate the process and changes into the culture. Process improvements needed will be identified and analyzed with Lean Six Sigma tools. The work groups will be empowered to implement changes identified and report back to the steering committee. To sustain results of changes implemented, audits at 6 months and 12 months will be utilized for each process improvement event. Evaluation, control and sustain activities are necessary for continuous quality improvements. The goal is to have multiple improvement events each year, at least 2 per year. We will measure the impact of improvements implemented from CMS HCAHPS scores.

Unique Community Need Identification Numbers the Project Addresses

CN.11: Patient Safety and Quality

How the Project represents a new initiative

This is a new initiative for Denton Regional Medical Center. It currently does not have a structure or feedback mechanism this program will implement for patient experience improvement.

Related Category 3 Outcome Measure(s):

IT-6.1: Percent improvement over baseline of patient satisfaction scores will be the focus of the patient satisfaction improvement plan.

An organizational strategy will be developed so that hospital can manage patient experiences and create avenues to implement the strategic plan/vision. Performance will be measured, among other factors, by the extent to which patient experience improves systematically.

In October 2005, the Joint Commission's Journal on Quality and Patient Safety published a series of case studies of healthcare institutions' efforts to improve both quality and safety. One of these was from Lehigh Valley Hospital in Allentown, Pennsylvania, which used active engagement of patients and families in attempting to improve patient safety. Anthony, R., Ritter M., Davis, R., Hitchings, K., Capuano, T. A., &Mawji, Z. (2005, October). Lehigh Valley Hospital: engaging patients and families. Joint Commission Journal on Quality and Patient Safety, 31(10), 566-572.

Weingart and colleagues (2006) examined inpatients' reports of service "incidents" — deficiencies in service quality such as waits/delays, poor communication, poor care coordination, lack of respect for personal preferences, or environmental issues. They found that roughly 40% of patients reported at least one incident and that reporting of incidents was associated with diminished patient satisfaction. Weingart, S. N., Pagoviceh, O., Sands, D. Z., Li, J.

M., Aronson, M. D., Davis, R. B., Phillips, R. S., & Bates, D. W. (2006, April). Patient-reported service quality on a medicine unit. International Journal of Quality in Health Care, 18(2), 95-101

Also, Kaldenberg and Trucano (2007) examined facility-level relationships between hospital-acquired infection (HAI) rates and patient perceptions of specific aspects of hospital quality in the State of Pennsylvania. Specifically, they chose three questions from an inpatient survey thought to measure practices that, when poorly executed, could create a more infection-prone environment: ratings of cleanliness; of the skill of the person who took the patient's blood; and of nurses' response to the call button. All three were found to be significantly, negatively correlated with HAI rates. Kaldenberg, D. & Trucano, M. (2007, August 22). The relationship between patient perceptions of hospital practices and facility infection rates: Evidence from Pennsylvania hospitals. Patient Safety & Quality Healthcare

Relationship to other projects

This project is to redesign to improve the patient experience. This project supports 111905902.4.3 RD-2 Potentially Preventable Readmissions- 30 days and 111905902.4.4 RD -3 Potentially Preventable Complications. An improved patient experience has been shown to correlate to improved quality of care and safety. This project also support 111905902.4.5 RD-4 Patient-centered healthcare. The project will implement training and improvement work on experience targets aimed to increasing patient satisfaction with the hospital, nurses and physicians that will result in a better patient experience.

Relationship to other Performing Providers' projects and Plan for Learning Collaboratives

The following providers are also proposing projects related to improving the patient experience:

- Las Colinas Medical Center: 020979301.2.1
- Medical Center of Lewisville: 094192402.2.1

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology:

Denton Regional Medical Center defined the population that will be directly impacted by the project as patients with Medicare and all patients who are the target of HCAHPS survey. The percentage of the population expected to be positively impacted by the project is all patients

surveyed, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed to determine the value to the health care system for each positive outcome realized as the result of our project. It was estimated based on CMS published penalties that in 5 years for not achieving satisfactory patient experience levels, 1.5% of Medicare revenues were in jeopardy. The Medicare average volume per year of 4,500 cases and rate per Medicare case of $8,827 was used to calculate the estimated loss of revenues using these penalty % for DY 2- 0.50%, DY 3- 0.75%, DY 4-0.94%, and DY5 -1.5% . This totaled $1,748,045 for a 5 year period.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, patient experience improves, which results from improved safety and quality of care that better health outcomes and reduced costs. This was estimated a portion of potential revenue value and totaled $349,609. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, his or quality of life is improved, productivity is increased, and there is a reduced burden on society. This was estimated a portion of potential revenue value and totaled $ 348,443.

The total value of the project was calculated at $2,446,907. Approximately 79% of the project value was assigned to the Category 2 project, $1,934,127 and 21% to the Category 3 project, $511,970.

Rationale/Justification: The economic value of each targeted improvement outcome from evidence based studies was used a guide for the overall value of project. Additional value was considered for resource investments needed, timelines, cost avoidance, and risk and project scope.

111905902.2.2	***2.4.1***	***2.4.1 (A-D)***	***IMPLEMENT A STRATEGIC IMPROVEMENT PROGRAM FOR PATIENT SATISFACTION (REDESIGN TO IMPROVE PATIENT EXPERIENCE)***	
Denton Regional Medical Center				*111905902*
Related Category 3 Outcome Measure(s):	*111905902.3.3*	*3 IT 6.1*	*Percent Improvement over baseline of patient satisfaction scores (all 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-3]: Establish steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient and/or employee experience. Steering committee should meet at least twice a month. Metric 1 [P-3.1]**:** Documentation of committee proceedings and list of committee Members. Baseline/Goal: Establish committee and meeting schedule Data Source: Meeting minutes, agendas, participant lists, and/or list of steering committee members Milestone 1 Estimated Incentive Payment *(maximum amount):* $240,520 **Milestone 2** [P-2]: Write and disseminate a patient/family experience strategic plan Metric 1 [P-2.1]: Submission of a	**Milestone 3** [P-11]: 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, noise levels and/or dining experience; better ambulatory experience; improved employee experience, etc.). Workgroups should be formed under the steering committee to work on experience targets. Detailed implementation plans should be created for each workgroup. Metric 1 [P-11.1]: Submission of implementation plan. Goal: Implement Data Source: Implementation plan Milestone 3 Estimated Incentive Payment *(maximum amount):*$163,998 **Milestone 4** [P-13]: Perform a mid-course evaluation of the results of	**Milestone 6** [I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families. Metric 1 [I-18.1]: Number of organization-wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: 10 displays Data Source: Verification of displays, methodology and CEO report to employees, physicians and steering committee Milestone 6 Estimated Incentive Payment *(maximum amount):* $526,312	**Milestone 7** [I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families. Metric 1 [I-18.1]: Number of organization-wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: 15 displays Data Source: Verification of displays, methodology and CEO report to employees, physicians and steering committee Milestone 7 Estimated Incentive Payment: $434,781

111905902.2.2	***2.4.1***	***2.4.1 (A-D)***	***IMPLEMENT A STRATEGIC IMPROVEMENT PROGRAM FOR PATIENT SATISFACTION (REDESIGN TO IMPROVE PATIENT EXPERIENCE)***	
Denton Regional Medical Center				*111905902*
Related Category 3 Outcome Measure(s):	*111905902.3.3*	*3 IT 6.1*	*Percent Improvement over baseline of patient satisfaction scores (all 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 and documentation of the dissemination of that plan throughout the organization Goal: Documented patient experience plan and communication strategies well defined Data Source: Completed patient experience plan, verification of communication throughout the organization. Milestone 2 Estimated Incentive Payment *(maximum amount):* $240,520	improvement projects/make necessary adjustments and continue with implementation <u>Metric 1</u> [P-13.1]*:* Submission of evaluation results. Goal: Evaluate 100% of improvement projects Data Source: Evaluation write –up Milestone 4 Estimated Incentive Payment: $163,998 **Milestone 5** [P-4]: Integrate patient experience into employee training. <u>Metric 1</u> [P-4.1]: 100 % of new employees who received patient experience training as part of their new employee orientation. Goal: Develop training Data Source: Implementation plan Milestone 5 Estimated Incentive Payment *(maximum amount):* $163,998		
Year 2 Estimated Milestone Bundle Amount: $481,040	Year 3 Estimated Milestone Bundle Amount: $491,994	Year 4 Estimated Milestone Bundle Amount: $526,312	Year 5 Estimated Milestone Bundle Amount: $434,781

111905902.2.2	***2.4.1***	***2.4.1 (A-D)***	***IMPLEMENT A STRATEGIC IMPROVEMENT PROGRAM FOR PATIENT SATISFACTION (REDESIGN TO IMPROVE PATIENT EXPERIENCE)***
Denton Regional Medical Center			*111905902*
Related Category 3 Outcome Measure(s):	*111905902.3.3*	*3 IT 6.1*	*Percent Improvement over baseline of patient satisfaction scores (all scores)*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,934,127			

Project Option 2.1.2 - Enhance/Expand Medical Homes: Medical Home in partnership with Mission East Dallas

Unique Project ID: 094194002.2.1

Performing Provider Name/TPI: Doctors Hospital at White Rock Lake/ 094194002

Summary

Provider: Doctors Hospital at White Rock Lake is a 218-bed acute care hospital in Dallas, Texas serving a 260.30 square mile area and a population of approximately 735,307. Doctors Hospital at White Rock Lake has a patient population that is made up of about 30.6% Medicaid and uninsured patients.

Intervention(s): This project will expand the delivery of care provided through the Patient-Centered Medical Home (PCMH) model through partnership with Mission East Dallas. Doctors Hospital at White Rock Lake will ensure that vital services at Mission are not lost as a result of the loss of Project Access Dallas funding, hire at least one additional case worker to ensure that high-risk and chronic-care patients are appropriately matched with community providers, like Mission East, develop shared health information exchange through EMR to increase the quality of care through more effective patient monitoring, medication management, and diagnostic capabilities, and increase the hours of availability at Mission East.

Need for the project: Due to a severe shortage of primary and specialty care access in Region 9, including the heavy burden borne by Parkland (Dallas County's public hospital), the Dallas-area healthcare community developed a successful initiative to reduce the burden ~~of~~ on acute care settings in the county through the creation of local clinics and Patient centered Medical Homes (PCMH), through Project Access Dallas.

In 2012, Mission East Dallas has a capacity of 10,100 patient visits per year, for approximately 3,200 unique patients. Unfortunately, the availability of funding for this crucial program has been redirected to other healthcare needs in the Dallas community. As a result of the unexpected unavailability of funding, Mission East Dallas planned to drastically reduce its scope, or even shut down, beginning in March of 2013 (coinciding with the withdrawn funding flow). To address this need, Doctors Hospital at White Rock Lake , through the implementation of this DSRIP project, will partner with Mission East Dallas, a community/charity clinic that has NCQA accreditation as a medical home. As a result of this partnership, Doctors Hospital at White Rock Lake and Mission East will be able to channel the high-risk and chronic-diseased patients to a more appropriate healthcare environment. In many cases, the ED is the sole point of entry to the healthcare system; this project will promote access to primary care resources and follow-up care, which will result in a reduction in unnecessary ED visits, and an overall cost-savings for the Dallas healthcare community.

As mentioned above, this project will increase Mission East's ability to serve patients after hours, as a large number of their most vulnerable patient population, including patients with chronic diseases, such as diabetes, need to utilize the clinic during hours when regular clinics are not available to them and the alternative is a local Emergency Room. Increased access to primary care is widely reported to provide value to patients and to communities.

Target population: Patients discharged from Doctors Hospital at White Rock Lake that are high-risk, or chronic disease patients that can seek follow-up care and medication management in an ambulatory care setting. We anticipate that about 2,500 encounters will be discharged that have a potential benefit from assignment to a Medical home.

Category 2 expected patient benefits: We do not expect any patients to directly benefit from this project in DY2, as Doctors Hospital at White Rock Lake and Mission East are working to implement their partnership including establishing referral processes and establishing IT systems to allow cross-facility EMR. In DY3, we expect that about 250 people will be assigned to the Mission East medical home, about 300 in DY4, and about 375 in DY5.

Doctors Hospital at White Rock Lake will begin assessing patients on discharge to determine whether a placement at the Mission East medical home would be an efficient use of health care resources. Because many high-risk and chronic care patients require ongoing medication management, follow-up care, and frequent intervention, it is often beneficial for the patient to have a "home base" in a primary care setting. This promotes the Waiver goals of promoting access to the appropriate care in the appropriate setting.

Category 3 outcomes: This project's focus is giving high-risk patients with chronic diseases access to primary care. This increase access to follow-up care and medication management in an ambulatory care setting will result in many healthcare outcomes, including a reduction in patients with hemoglobin levels above 9.0% (IT-1.10 Diabetes Care), and an increase in cervical cancer screenings in women between the ages of 21 and 61 (IT-12.2 Cervical Cancer Screening).

Project Description

Dallas County's public hospital, Parkland, is at, or has exceeded, its currently available primary and specialty care capacity. Community hospitals and private physicians are limited in their ability to meet the day to day routine and preventative care needs of the local population, based on current reimbursement/financing mechanisms. A successful initiative to reduce the burden of care in the county has been the creation of local clinics and Patient centered Medical Homes (PCMH) to provide preventative and routine care, reducing the volume and expense of acute care emergency room and hospital admissions due to unavailability of preventative care. To address this challenge, Doctors Hospital at White Rock Lake will join with Mission East Dallas to expand and enhance the delivery of care provided through the PCMH model. This plan builds upon existing resources/relationships and focuses on transforming care in East Dallas toward a

patient-centered medical home. The PCMH provides a primary care "home" for the patients. Patients are assigned to a "home" with a health care team who provides services based on a patient's unique health needs, effectively coordinates the patient's care across inpatient and outpatient settings and proactively provides preventive, primary, routine and chronic care.

Benefits of this Medical Home project include:

- a single point of accessible, continuous, comprehensive and coordinated medical care which includes specialists, hospital and post-acute care.

- A dedicated nurse or social worker manager from Doctors Hospital at White Rock Lake that will respond to patient referrals, ~~to~~ facilitate efficient hospital discharge, and coordinate post-acute care connection to a primary care clinic or physician.

- Increased access to primary care services through the transportation, health navigation, and care plans implemented by Mission East in its role as the patients' medical home.

- More efficient medication management for patients with chronic diseases that are often on several medications to manage their symptoms and prevent complications, as well as assistance from the medical home staff in obtaining more affordable generic products through patient assistance programs.

Staff performing specialty physician care referral management are dedicated to connecting patients and their health information to specialty care network, upon referral from a primary care provider~~.~~ to reduce the number of days between the primary care physician's decision for a specialty care consultation and the patient's actual specialty care physician visit.

- Dedicated registered Nurses and/or advance practice nurses to provide case management and house calls to

provide chronic disease management to complex patients. It is estimated that 5-10% of the targeted population will require Case Management services (and house call when necessary), which enables Mission East Dallas to accept the sickest, most challenging patients from participating hospitals.

Project Goals

This DSRIP project to establish a Medical Home partnership between Doctors Hospital at White Rock Lake and Mission East seeks to accomplish several goals: (1) expanding Mission East's ability to continue offering its services as a medical home in light of the loss of Project Access Dallas funding, (2) increasing the number of patients from Doctor's Hospital at White Rock Lake that have access to a medical home, and (3) establishing shared information technology share clinical data among the entities.

Challenges/Issues

Community hospitals and private physicians are limited in their ability to meet the needs of the growing number of the uninsured population. This project aims to expand access to this population by coordinating with Mission East Dallas to increase efficiency and reduce the cost of providing care to this population. Options for the uninsured to access coordinated and comprehensive health care are limited. Doctors Hospital's service area extends south and west out the I-80 / 175 corridor where time and access to care is limited, especially for under-resourced populations.

This project was specifically selected because the community has a ten year history of working together to address these needs of eligible uninsured residents in Dallas County through Project Access Dallas. Although that program has disbanded, Doctors Hospital at White Rock Lake and Tenet Healthcare remain committed to the community goal of providing patients with ~~additional~~ high quality services in the appropriate setting that are accountable and measurable and improve their care and health care experience.

5 Year Expected Outcomes

The expected outcome of this partnership between Mission East and Doctors Hospital at White Rock Lake is an increased access to primary care for those high-risk and chronic care patients that require follow-up care, medication management, and preventative care that are currently utilizing the ED as a resource of disease management and primary care. Through increased access, these patients will see greater management of their chronic disease (such as diabetes), as well as receive vital preventative care (such as cervical cancer screenings).

How this project is related to other regional goals

A major goal of Region 9 is to provide improved access to coordinated primary and specialty care by underserved individuals in the region. This project would contribute to achieving that goal in East Dallas by collaboration between Doctors Hospital at White Rock Lake and Mission East Dallas, which is committed to identifying eligible uninsured residents and providing the option of access to a patient centered medical home.

Starting Baseline

Mission East Dallas, a NCQA recognized medical home, has not had a hospital partner like several other indigent care providers. Their unduplicated patients have been lower than other area clinics because they did not have hospital partners. This partnership will provide additional support in expanding Mission East Dallas' capacity from 10,100 patient visits per year. The clinic had 3,200 unique visits in 2012. Currently, Doctors Hospital at White Rock Lake does not directly refer any patients to Mission East, and this project will result in increased access to a

medical home for patients with a high-risk or readmission or a chronic disease that can be managed in an ambulatory setting.

Rationale

As indicated in the Dallas Fort Worth Hospital Council's RHP 9 Community Needs Assessment, there is a strong demand for primary and specialty care services. The demand for hospital, primary care and specialty care services exceeds the supply of available medical physicians in the hospital's service area, thus limiting health care access for many low level management or specialized treatment for prevalent health conditions. Many primary care physicians accept a limited number of the Medicaid/Uninsured population due to the lack of coordination of care and access to appropriate ancillary services. Consequently, many residents seek primary care treatment in emergency care settings resulting in increased healthcare costs, increased emergency department wait times, and visits which would be avoidable if primary care was local and available. Thus, the improved and continued support to physicians, community/charity clinics and hospitals through the exchange of information, coordination of services with interconnected health systems, physicians and community/charitable clinics and the implementation of innovative approaches can have a significant impact on the uninsured ability to access care and improve outcomes. We have selected this project to enhance the role of the of community/charity clinics by creating more patient centered medical care home options in the region.

Project Components:

This project will accomplish the following project components:

a) Improve data exchange between hospitals and affiliated medical home sites
    - Doctors Hospital at White Rock Lake will work with Mission East in DY2 and DY3 to integrate the two entities' information technology to allow shared access to patient records. This process will increase the efficiency of medication management, and ensuring proper follow-up care.

b) Develop best practices plan to eliminate gaps in the readiness assessment
    - Case managers at Doctors Hospital at White Rock Lake will work to address best practices in identifying, educating, and directing patients to the services and support offered through their assigned medical home, Mission East.

c) Hire and train team members to create multidisciplinary teams including social workers, health coaches, care managers, and nurses with a diverse skill set that can meet the needs of the shared, high-risk patients

- Doctors Hospital will hire or train at least one additional case manager in DY 3 as part of its effort to increase patients' assignment to a medical home. Existing case managers will be trained to identify high-risk and chronic disease patients that would benefit from being assigned to a medical home for follow-up care and future primary care needs.

d) Implement a comprehensive, multidisciplinary intervention to address the needs of the shared, high-risk patients

   - Mission East and Doctors Hospital at White Rock Lake have worked to develop and implement a collaboration focused on treating high-risk patients in a more appropriate setting. This project seeks to get patients the appropriate care in the appropriate setting, rather that utilizing the ED as the primary access point for managing their disease.

e) Evaluate the success of the intervention at decreasing ED and inpatient hospitalization by shared, high-risk patients and use this data in rapid-cycle improvement to improve the intervention

   - Doctors Hospital at White Rock Lake and Mission East will meet throughout DY2 and DY3 to plan and coordinate this DSRIP project. These meetings and workgroups will continue to confer in DY4 and DY5 to identify inefficiencies, ensure streamlined medical home assignment, and track benefits of patients that are assigned to Mission East.

f) 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.

   - Doctors Hospital at White Rock Lake and Mission East are committed to continuing the strong partnership that has formed as a result of this DSRIP project. As part of the meetings identified in (e), each entity will evaluate ways to improve quality for patients and the overall healthcare delivery system.

Reason for selecting milestones/metrics: Our milestones measure an increased population receiving care through a PCMH model of care: (1) we are establishing and implementing medical home assignment criteria, (2) we are utilizing evidence based training materials for

medical homes based upon model change concepts, and (3) we are increasing the number of eligible patients assigned to a medical home

Community Needs Assessment Identification Number

- CN.3 Healthcare Capacity
- CN.8 Chronic Disease

Describe how the project represents a new initiative or significantly enhances an existing delivery system reform initiative

The Medical Home partnership between Doctors Hospital at White Rock Lake and Mission East accomplished several goals: (1) expands Mission East's ability to continue offering its services as a medical home (where it otherwise would have been significantly reduced or disbanded), and increases the number of patients from Doctor's Hospital at White Rock Lake that have access to medical home, (2) through the health information exchange, links clinical data sharing between performing providers, physicians and community/charity clinics and (3) establishes a quality improvement committee to look at clinical outcomes.

Related Category 3 Outcome Measures

- IT-1.10 Diabetes Care. Our goal is to decrease the percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who have hemoglobin A1c (HbA1c) control >9.0%.
- IT-12.2 Cervical Cancer Screening. Increase the number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years.

Reasons/rationale for selecting the outcome measures: This project's implementation will allow patients identified as high-risk or with a chronic disease to have access to primary care services, follow-up care, and case management. Access to ambulatory care will increase diabetes management, as measured in IT 1.10. Additionally, once these patients are assigned to a medical home, they will have increased access to preventative healthcare, such as cervical cancer screenings, as measured in IT 12.2. Not only do these outcomes represent increased healthcare availability for these high-risk patients, it also represents an overall cost-savings to the healthcare delivery system.

Relationship to other Projects

Other related projects include Project 0904194002.2.2 (Expand Care Transitions Programs), which implements an enhanced discharged planning process to ensure that patients are partnered with community resources, have comprehensive follow-up care instructions, and

implement a follow-up call to ensure patients are adhering to a follow-up care regimen, and have contacted a primary care provider where necessary.

Relationship to other Performing Provider Projects and Plan for Learning Collaborative

Other medical home projects include:

Children's Medical Center:	138910807.2.1
HCA Medical City Dallas Hospital:	020943901.2.4
Methodist Dallas Medical Center:	135032405.2.3
Parkland Health & Hospital System:	127295703.2.1
Parkland Health & Hospital System:	127295703.2.11
Texas Health Presbyterian Hospital Dallas:	020908201.2.3
UT Southwestern Medical Center:	126686802.2.1

Plan for Learning Collaborative. Doctors Hospital at White Rock Lake, Tenet Healthcare, and Mission East Dallas will be establishing a learning collaborative to share lessons learned and best practices. This collaborative will span DYs 2-5 and include meetings, workgroups, or conference calls on at least a quarterly basis. Meeting agendas and notes, including shared learning, will be documented and reported through DSRIP program reporting requirements.

Project Valuation

$2,555,600. In determining the value of this project, Doctors Hospital at White Rock Lake considered the extent to which patients will benefit from assignment to a medical home increased will address the community's needs, the high-acuity population this project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including providing the appropriate care in the appropriate setting, supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure). Specifically, Doctors Hospital at White Rock Lake considered the significant cost savings that will result from the successful implementation of this project when patients are navigated away from high-cost treatment sites such as Emergency Rooms, investment in information technology to share patient data with Mission East, and costs associated with services that are scheduled to be lost through Project Access Dallas, including

UNIQUE PROJECT: *094194002.2.1*	***PROJECT OPTION:*** *2.1.2.~~1~~*	***PROJECT COMPONENTS:*** *~~2~~.1.2 (a-f)*	***Title:*** *Medical Home in partnership with Mission East Dallas*	
Doctors Hospital at White Rock Lake				*094194002*
Related Category 3 Outcome Measure(s):	*094194002.3.1* *094194002.3.2*	*3.IT-12.2* *3.IT-1.10*	*-Cervical Cancer Screening (HEDIS 2012)* *-Diabetes Care: HbA1c poor control (>9.0%) – NQF 0059*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-6] Establish/ implement criteria for medical home assignment Metric 1: P-6.1: Medical home assignment criteria Data source: Submission of medical home assignment criteria Baseline/Goal: currently, Drs. Hospital at White Rock Lake does not directly to refer to Mission East Dallas (0 patients assigned in 2012). We estimate that about 2,500 discharges per year will be eligible for medical home assignment based on diagnosis code and internal protocols for referral. **Milestone 1** Estimated Incentive Payment: $554,000		**Milestone 2 ~~5~~ [P-8]** Develop or utilize evidence based training materials for medical homes based upon model change concepts Metric 1 : P-8.1: Documentation of training materials Data Source: Training materials Baseline/Goal: Establish 1 set of training materials for use within Drs. Hospital to educate providers and staff on referral process and benefits of partnering with Mission East as a medical home. **Milestone 2** Estimated Incentive Payment: $304,600 **Milestone 3 ~~6~~ [I-12]** Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric 1 ~~6~~: I-12.1: Increase the percent of eligible patients assigned to medical homes, where "eligible" by 10%. Data Source: eClinical Works EMR Baseline/Goal: Assign 10% of DY2 baseline eligible population to	**Milestone 4 ~~8~~ [I-12]** Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric 1 : I-12.1: Increase the percent of eligible patients assigned to medical homes Data Source: eClinical Works EMR Baseline/Goal: Assign 12% of DY2 baseline eligible population to Mission East – about 300 patients. **Milestone 4 ~~5~~** Estimated Incentive Payment: $644,400	**Milestone 5 ~~10~~ [I-12]** Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric ~~10~~: I-12.1: Increase the percent of eligible patients assigned to medical homes~~,~~ Data Source: eClinical Works EMR Baseline/Goal: Assign 15% DY2 baseline eligible population to Mission East – about 375 patients. **Milestone 5** Estimated Incentive Payment: $748,000

UNIQUE PROJECT: *094194002.2.1*	***PROJECT OPTION:*** *2.1.2.1*	***PROJECT COMPONENTS:*** *-2.1.2 (a-f)*	***Title:*** *Medical Home in partnership with Mission East Dallas*	
Doctors Hospital at White Rock Lake				*094194002*
Related Category 3 Outcome Measure(s):	*094194002.3.1* *094194002.3.2*	*3.IT-12.2* *3.IT-1.10*	*-Cervical Cancer Screening (HEDIS 2012)* *-Diabetes Care: HbA1c poor control (>9.0%) – NQF 0059*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Mission East – about 250 patients. **Milestone 3** Estimated Incentive Payment: $304,600			
Year 2 Estimated Milestone Bundle Amount: $554,000	Year 3 Estimated Milestone Bundle Amount: $609,200		Year 4 Estimated Milestone Bundle Amount: $644,400	Year 5 Estimated Milestone Bundle Amount: $748,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD~~):~~ $2,555,600				

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Project Option 2.12.1 - Implement/Expand Care Transitions Programs

Unique Project ID: 094194002.2.2

Performing Provider Name/TPI: Doctors Hospital at White Rock Lake/094194002

Summary

Provider: Doctors Hospital at White Rock Lake is a 218-bed acute care hospital in Dallas, Texas serving a 260.30 square mile area and a population of approximately 735,307. Doctors Hospital at White Rock Lake has a patient population that is made up of about 30.6% Medicaid and uninsured patients.

Intervention(s): This DSRIP project will develop a standardized care transition process for case managers to utilize in discharging patients, increase partnership with community-based providers to ensure that patients receive appropriate post-acute care services in an appropriate setting. To accomplish this, Doctors Hospital at White Rock Lake will hire an additional ED case manager, engage with community organizations, perform follow-up calls to ensure proper adherence to care instructions, and determine whether the patient requires additional community placement for ongoing primary or preventative care. The intent of this project is to improve the core discharge planning function and support a safe, effective, and efficient transition to post-acute care. The ultimate goal will be to reduce preventable readmissions by identifying and developing comprehensive discharge plans that meet the needs of patients with varying levels of acuity, resources, and access to care outside the ED.

Need for the project: According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. Evidence suggests that the rate of avoidable re-hospitalization can be reduced by improving core discharge planning and transition processes out of the hospital, and by improving transitions and care coordination at the interfaces between care settings.

Target population: This project will target patients discharged from Doctors Hospital at White Rock Lake with one of the following primary diagnoses: COPD (DRGs 190-192), Pneumonia (193-195), Acute MI (280-282), Heart failure (291-293), and Diabetes (637-639).

Category 2 expected patient benefits: The ultimate goal will be to reduce preventable readmissions by identifying and developing comprehensive discharge plans that meet the needs of the high-risk population early in the patient stay. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. We do not expect any patients to directly benefit in DY2 or DY3, as we will be developing and implementing a standardized care transition process and hiring an additional ED case manager to facilitate partnering patients with community-based resources for primary care, preventative care, and follow-up care. In DY4, we

expect that about 198 discharge encounters will receive care transition based on approved clinical protocol, and about 329 in DY5.

Category 3 outcomes:

- IT-1.10 Diabetes Care. Our goal is to decrease the percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who have hemoglobin A1c (HbA1c) control >9.0%.

Project Description

This project will support and enhance discharge planning assessment and intervention, with the development of tools that assist case managers to improve the core discharge planning function and support a safe, effective, and efficient transition to post-acute care. The ultimate goal will be to reduce preventable readmissions by identifying and developing ~~A~~ a comprehensive and reliable discharge plan, partnership with community-based organizations, additional staff to facilitate the care transition process, and providing ~~along with~~ post-discharge support to ensure patients are seeking follow-up care and have primary care resources in the community. goal of the project is to ensure that the hospital discharge is accomplished appropriately and that care transitions occur effectively and safely Transitions from inpatient care to the home setting will be supported and readmissions or revisits within 30 to 60 days will be reduced. Following the implementation of the project, quality improvement activities will be conducted to foster continued learning by staff regarding the most effective methods for ensuring quality care transitions.

Required Core Project Components

This project will accomplish the following project components:

a) Review best practices from a range of models (e.g. RED, BOOST, STAAR, INTERACT, Coleman, Naylor, GRACE, BRIDGE, etc).
    - Doctors Hospital at White Rock Lake will review best practices to determine the most appropriate tool for use in creating standardized transition process in DY2.
b) Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool (e.g. Institute for Healthcare Improvement (IHI)
    - The case management coordinator will conduct an analysis in DY2 to inform the policies and protocols developed for standardized care transitions.
c) Integrate information systems so that continuity of care for patients is enabled
    - Doctors Hospital at White Rock Lake will work with community partners, such as Mission East, to ensure that information systems are compatible and enable each provider to more efficiently manage the patients throughout the transition and follow-up process.

d) Develop a system to identify patients being discharged potentially at risk of needing acu te care services within 30-60 days
    - In DY2 and DY3, Doctors Hospital at White Rock Lake will identify patient being discharge with a high risk of readmission. This information will assist in targeting those patients for more immediate ambulatory care interventions, and more frequent follow up to attempt to prevent worsening health outcomes, or a subsequent acute care procedure.

e) Implement discharge planning program and post discharge support program
    - In DY2, Doctors Hospital at White Rock Lake will develop a comprehensive discharge planning program that utilizes providers in the community, as well as follow-up calls to discharged patients to ensure proper follow-up care.

f) Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.
    - Throughout the Waiver, Doctors Hospital at White Rock Lake will continue to meet with and consult with community-based providers to ensure an efficient healthcare delivery system that is focused on providing appropriate care in the appropriate setting.

g) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Reason for selecting milestones/metrics: Our milestones were chosen to (1) develop a standardized transition process, (2) partner with community-based organizations to ensure that patients are matched with an appropriate ambulatory setting, (3) hire/train an additional case manager to handle a more in-depth process, and (4) increased population being discharged using standardized care transition protocols. These steps are critical in developing a meaningful discharge process that addressing ongoing patient needs for follow-up care, medication management, and preventing unnecessary readmission.

Community Needs Assessment Identification Number

- CN.3 Healthcare Capacity
- CN.8 Chronic Disease

Describe how the project represents a new initiative or significantly enhances an existing delivery system reform initiative

Currently, the discharge process is disjointed and does not focus on post-acute care follow-up. As a result, there are preventable readmissions returning to the ED as their primary source of medical care. This project will significantly enhance the discharge process, partnership with community-based organizations, and follow-up calls to ensure that patients are seeking appropriate care in the appropriate settings.

Goals and Relationship to Regional Goals

The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. The discontinuity of care during transitions typically results in patients with serious conditions, such as heart failure, chronic obstructive pulmonary disease, and pneumonia, falling through the cracks, which may lead to otherwise preventable hospital readmission. The goal of this DSRIP project is to ensure that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely. Providing appropriate care in the appropriate setting is a major goal of the Waiver and has been a focus for Tenet and Doctors Hospital at White Rock Lake, as well as other Region 9 providers. This project is part of a Regional effort to streamline the discharge process and ensure that patients are receiving the follow-up care they need in ambulatory care settings, which will result in improved patient outcomes and cost savings to the healthcare delivery system.

Challenges/Issues

Due to limited resources in the Dallas healthcare delivery system, it can be difficult to hire, train, and educate staff on the importance of standardized care transitions and community placement. Additional staff and training will be put in place to ensure that current personnel are aware of all existing and new community-based organizations that Doctors Hospital White Rock Lake is partnering with to create a more comprehensive care transition process.
The identification of patients at risk for readmission is an area of research and growing experience. Another ~~primary~~ challenge will be to standardize an approach to identifying risk categories and factors. Doctors Hospital at White Rock Lake will identify the most useful risk assessment tool or modify existing tools to meet the specific needs of the project.

5-Year Expected Outcome

Doctors Hospital at White Rock Lake will implement a standardized care transition process, develop partnerships with community-based organizations, hire/train an additional ED case

manager, and improve the percentage of patients receiving standardized care transitions by at least 25% in DY5. By focusing on the care transition process, patients can be added to care management teams, which will begin to use standard policies and protocols to reduce complications, readmissions, unnecessary ED visits, and improved overall health. Personal contact by healthcare personnel would encourage at-risk populations to become actively engaged in managing their own health. The expected result will be decreased ED visits, decreased specialty clinic visits and decreased preventable admissions/readmissions.

Starting Point/Baseline

As of 2012, the baseline year, Doctors Hospital at White Rock Lake does not have any designated case managers in the ED. Hospital-wide managers are often overloaded and unable to spend sufficient time working with the patient to determine the most appropriate community link. There is no coordinated system of referral to community-based organizations in place. Additionally, there is no mechanism to provide follow-up calls to each patient discharged, which would be useful to ensure that the patient was successful in meeting with his or her community provider.

Rationale

It is important to coordinate care with facilities outside a provider's own delivery system so that patients going in and out of the delivery system can receive optimal care, wherever possible. When a patient's transition is fractured or duplicative, the repercussions can be far-reaching, including 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.Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, duplication of effort and inefficiencies. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Patient transition is a multidimensional concept and may include transfer from the hospital to home, or nursing home, or from facility to home- and community-based services, etc.

According to the Medicare Payment Advisory Committee, 76 percent of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable. This has been identified as perhaps the largest opportunity to improve the efficiency of care in the Medicare population. Non-Medicare populations affected include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization can be reduced by improving core discharge planning and transition processes out of the hospital, and by improving transitions and care coordination at the interfaces between care settings.

Related Category 3 Outcome Measures

OD-1: Primary Care and Chronic Disease Management

- IT-1.10 Diabetes Care: HbA1c poor control

Our goal is to decrease the percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who have hemoglobin A1c (HbA1c) control >9.0%.

Reasons/rationale for selecting the outcome measure: This project's implementation will create a streamlined discharge process that focuses on linking patients with community-based providers that can address their post-acute care needs such as follow-up care, medication management, and preventative primary care. One of the main causes of continuous readmission are diabetes patients that do not have an alternate venue of care. These patients seek regular treatment and disease management services through the ED, which is inefficient to the Dallas healthcare delivery system. By placing these individuals with community organizations, it will improve patient outcomes, provide for the appropriate care in the appropriate setting, and allow high-acuity patients faster access to emergency services.

Relationship to Other Projects

This project links with the Category 2.1 Medical Home project in coordination with Mission East Dallas (094194002.2.1). The patient population expands beyond Mission East Dallas' population to serve an expanded community with enhanced case management. This project is part of Tenet's larger plans to expand and develop primary care and specialty care services in the Dallas County community, while improving access to care and containing the costs of care.

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

This project will complement Parkland's primary care clinics, as well as other providers' efforts to improve discharge planning and case management to provide a more efficient healthcare delivery system. Providing appropriate care in the appropriate setting is a major goal of the Waiver and has been a focus for Tenet and Doctors Hospital at White Rock Lake, as well as other Region 9 providers.

Plan for Learning Collaborative. We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

$613,900. In determining the value of this project, Tenet considered the extent to which newly-implemented or expanded care transitions programs will address the community's needs, the population which this project will serve, the resources and cost necessary to implement the project, and the project's ability to meet the goals of the Waiver (including supporting the development of a coordinated care delivery system, improving outcomes while containing costs, and improving the healthcare infrastructure).

The valuation of this project takes into account the potential of better care transition management to improve quality of care and thereby improve patient satisfaction and patient outcomes. The valuation of this project also takes into account the challenges that Tenet will face in implementing this project in the hospital setting. Tenet will also work closely with Mission East Dallas on enhanced case management and smooth transitions for its patient population.

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UNIQUE PROJECT: *094194002.2.2*	***PROJECT OPTION:*** *2.12.1*	***PROJECT COMPONENTS:*** *2.12.1 (a-g)*	*Implement/Expand Care Transitions Program*
Doctors Hospital at White Rock Lake			*094194002*
Related Category 3 Outcome Measure(s):	*094194002.3.3*	*~~3.~~IT-1.10*	*Diabetes Care: HbA1c poor control (>9.0%) – NQF 0059*

Year 2 (10/1/2012 – 9/30/2013)	**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]: Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge. Metric 1 [P-4.1]: Care transitions assessment. Baseline/Goal: In 2012, the facility had 7,746 total discharge encounters. 1,316 of those were in the target population. As of 2012, there were 0 case managers dedicated to the ED case managers. Goal: submission of care transitions assessment. Data Source: Care transitions assessment and resource planning documents. Milestone 1 Estimated Incentive Payment: $69,250 **Milestone 2** [P-2]: Implement standardized care transition processes. Metric 1 [P-2.1]: Care transitions policies and procedures. Baseline/Goal: Currently, there are	**Milestone 3** [P-6]: Train/designate more ED case managers. Metric 1 [P-6.1]: HR records. Baseline/Goal: Train / designate 1 additional ED case managers. Data Source: Staffing and implementation plan. Milestone 2 Estimated Incentive Payment: $152,300	**Milestone 4** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Baseline/Goal: 15% improvement over DY2 baseline. Data Source: Registry or EHR report/analysis. Milestone 4 Estimated Incentive Payment: $161,100	**Milestone 5** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Baseline/Goal: 25% improvement over DY2 baseline. Data Source: Registry or EHR report/analysis. Milestone 5 Estimated Incentive Payment: $162,000

UNIQUE PROJECT: *094194002.2.2*	***PROJECT OPTION:*** *2.12.1*	***PROJECT COMPONENTS:*** *2.12.1 (a-g)*	*Implement/Expand Care Transitions Program*
Doctors Hospital at White Rock Lake			*094194002*
Related Category 3 Outcome Measure(s):	*094194002.3.3*	*~~3.~~IT-1.10*	*Diabetes Care: HbA1c poor control (>9.0%) – NQF 0059*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
sporadic and uncoordinated procedures used on discharge. Goal: Implement one care transition policy / procedure to be used for all discharge. Data Source: Policies and procedures of care transitions program materials. Milestone 2 Estimated Incentive Payment: $69,250			
Year 2 Estimated Milestone Bundle Amount: $138,500	Year 3 Estimated Milestone Bundle Amount: $152,300	Year 4 Estimated Milestone Bundle Amount: $161,100	Year 5 Estimated Milestone Bundle Amount: $162,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $613,900			

97899

Project Option: 2.13.1 Design, Implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population with required components a) through e) (Lakes Regional Cognitive Enhancement Therapy)

Unique Project ID: 121988304.2.1 (Pass 2)
Performing Provider/TIP: Lakes Regional MHMR Center/121988304

Provider: Lakes Regional MHMR Center is a community-based provider of out-patient services to adults with serious mental illness, chemical dependency; to children and adolescents with serious mental illness or emotional disorders; to persons with autism, pervasive developmental disorders or intellectual disabilities; and to infants and toddlers with developmental delays. Lakes Regional MHMR Center's service area includes 12 Texas counties with a total population of 633,045 and spans an area of 6,762 square miles. The service area crosses four Regional Healthcare Partnership (RHP) areas and is mostly rural. Lakes Regional's community programs serve over 9,500 individuals each year Over 95% of our consumers are either Medicaid eligible or indigent.

Intervention(s): This project is the therapeutic application of a neurodevelopmental approach to recovery from schizophrenia and like conditions through activating frontal lobe executive function with computerized challenges, social awareness training and socially skills development over the course or a year. The program has been shown in evidence-based trials to help participants make substantial and sustainable gains in functioning on a number of dimensions not the least of which are community engagement and employability in more normalized settings.

Need for the project: To gain the skills necessary for recovery beyond stabilization, individuals need improvement of the sort that leads to lowering risk of hospitalizations, encounters with law enforcement and emergency departments, individuals with schizophrenic related disorders need adaptive social skills beyond the supportive array available through state funding to access a future of community connection, self-direction and self-esteem. The program is a needed addition to services allowing an avenue of progression in treatment as an option for individuals that have reached stability of symptoms on medication with potential for remarkable and lasting impact.

Target population: The target population is individuals with a schizophrenic related disorder the symptoms of which are stable on medication and other programmatic criteria. Approximately 95% of our patients are either Medicaid eligible or indigent.

Category 1 or 2 expected patient benefits: The project will provide a minimum of 60 graduates with improved cognitive function, motivation, problem solving, memory retention, mental resilience and flexibility by the end of DY5. . Each graduating participant will receive 168 hours over 48 weeks of computer-based cognitive exercises, psycho-educational group and individual coaching. The anticipated 12,096 cumulative client hours of training are expected to yield

productive, contributive members to the community with an increase in sense of control over symptoms and self-sufficiency.

Category 3 outcomes: IT-6.1 Patient Satisfaction
The projected outcomes relate to an improvement in access to care, the quality of care and health outcomes, as well as an overall improvement in health for the target population. To demonstrate improvement patient satisfaction on a validated instrument and process will inform the project on the improvement relevance to participants while reinforcing to each individual their own sense of efficacy. The projected improvement over baseline percentage is 10% for DY-4 and 15% for DY-5.

Project Description
Rural behavioral health clients, especially those with Schizophrenia like conditions, rarely have access to new and effective developments in therapeutic techniques with the possibility of improving functioning and quality of life beyond traditional medication and case management approaches. Compounded by the difficulties of distance, socio-economics and sparse delivery systems innovations, these clients usually receive diluted versions of skills programs after several revisions aimed at shortening and modifying for unskilled providers. Cognitive Enhancement Therapy is an evidence-based neurodevelopmental intervention for individuals with Schizophrenia and Schizoaffective disorders. Proven effective by a NIMH funded research grant and resilient with a three year follow-up study, CET is focused on the neurodevelopmental impairments of the disorders: specifically, the reduced frontal lobe cognitive functioning as it affects internal mental processes particularly socially appropriate interactions (NIMH Grant MH-30750). CET is a set of structured activities that exercise the brain's neuroplasticity capabilities to enhance neurocognitive development and social cognition using computer-based interactive software, group-based interactions and individual coaching sessions on a weekly schedule over forty-eight weeks. Each program is co-facilitated by two therapists with specific program related training to provide the computer lab assistance, interactive group, and individual coaching sessions (Hogarty, G. & Greenwald, D., 2006). Two overlapping groups of 8-12 participants can be run by a team. After the start-up preparations, the groups will begin in DY3 through DY5. Over the 12 month program, participants will (tracked by internal program measures) increase processing speed (a foundation for learning), social cognition (understanding of social cues) and social adjustment (appropriate response to social interactions).

Goals and Relationship to Regional Goals

The goals for participants in CET are measurable improvements in: quality of life; satisfaction in the treatment experience; improvement in Cognitive Symptoms of Impoverished, Disorganized and Rigid Thinking; increased Social Cognition traits - Tolerant, Supportive, Perceptive, and Self-Confident. The goals of the project for the Performing Provider is expanding the capacity of behavioral health services to better meet the needs of the patient population and community so that care can be better coordinated and the patient can be treated as a whole person, potentially leading to better outcomes and experience of care. Upon demonstrating success

through the waiver, Lakes Regional MHMR Center (LRMHMRC) will expand CET to other rural clinics and join other community centers in sharing the outcomes and advances in treatment with other mental health professionals in Texas.

Challenges

Under current funding constriction of mental health programming in Texas, stable and medicated individuals with a schizophrenic like condition are provided minimum services without expectation of their improving to the point of joining their community in a productive way. Providing this population with an effective training program that will lead to appropriate community involvement, reduced involvement with the criminal justice system, reduced inappropriate use of the emergency department (ED) a better quality of life, and increased personal efficacy, as well as, hope for their futures and positive recovery influence upon those individuals currently less stable are the challenges targeted by this project.

The project relates to the Region 9 goals to improve access to Behavioral Health services (CN.5) and to reduce the unnecessary use of Emergency Departments (CN.12). CET will also address individuals with Chronic Disease conditions (CN.8) by providing specialized recovery services.

The 5-year expected outcome:

Increases in cognition/thinking will improve motivation, problem solving, memory retention, mental resilience and flexibility (Hogarty, G. & Flesher, S., 1999). Social improvement will elevate participants' perspective taking, understanding themes and meanings, and appreciation of both spontaneity and enjoyment goal achievement. They will be able to identify meaningful adult roles as part of their personal recovery plan. Self-management skills will allow response to subjective cues of distress and adjustment to disability (Hogarty, G., Greenwald, D. & Eack, S., 2006). Since retention and program impact is high in the research literature, it is anticipated that the outcome will be an on-going program with ~~in excess~~ a minimum of 60 graduates having completed 168 service events and involved successfully in the community at large and in an alumni program that provides influence on newer individuals in clinic services opening recovery hope and making the possibilities of better days tangible. In short, the expectation is new productive and engaged citizens in the community less dependent on the community services than in the past.

Starting Point/Baseline:

CET is a new program design that will require basic development. Only one such program (privately funded) exists in North Texas for a self-selected population and is inaccessible to the population the LRMHMRC clinics serve. The LRMHMRC MH clinic has a large population of individuals who are stable on medications, in housing, and finances as potentially qualifying participants. These clients currently receive minimal services and many express the desire for more involvement to progress in their lives; however, State mediated managed care services are restricted. The managed care system effecting these clients had growth in enrollment that

outpaced funding such that the funding per person served is 30% less than when the program started in 1999 and is half that of the state average for other LMHAs (TriWest/Zia Partners, 2010). Given that Texas is 50th in mental health funding nationwide (National Alliance on Mental Illness, 2011), this means that the funding per person served in RHP 9 is among the lowest in the nation. Under the guidance of CET origination team members as contracted trainers, LRMHMRC will develop the staff, program components, evaluative instrumentation, and participant criteria for establishing baseline and selection in DY2 of the waiver. Tie to RHP Goals needed.

Rationale

2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.

One of the bedrock ideas of the recovery concept is the normalization of routine interactions within the community which includes socially appropriate behavior for acceptance and reciprocity. The CET design is meant to enhance the mental capacities that underlay social awareness and appropriate interaction. Through the program participants would build the internal skills to be able to interact with the community in which they live with greater understanding and ease (Hogarty, G. & Flesher, S., 1999). These skills will lead to inclusion and acceptance in social interactions, connection with social groups and the ability to acquire and sustain employment (Eack, S., et al, 2011).

Fundamentally, the skills will improve the quality of life of the individual through more normalized social involvement and the inherent benefits of a sense of inclusion in social participation. This will make participants individually and as a group less likely to make inappropriate ER visits and encounter the criminal justice system. Against alternatives CET is evidenced to be the best available treatment to move individuals in this population from merely stable with cognitive inflexibility and social withdraw toward normalization and true recovery for the rural mental health center population. For the reasons above, 2.13.1 Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population was the option chosen.

Project Components

The project components of 2.13.1 are:

1. Assess size, characteristics and needs of target population- this is to be determined through gap analysis surveying in DY2.
2. Review literature- DY2 will also be a period to review the relevant literature and engage services in project development.
3. Develop project evaluation plan- a Plan, Do Study, Act (PDSA) approach will be instituted for continuous evaluation and quality improvement; the Adult Needs and Skills Assessment (ANSA) scores taken quarterly along with the SF-36 (a validated quality of life survey) responses and in program functional testing will be used in the evaluation process.

4. Design models- Cognitive Enhancement Therapy is an Evidenced Based Program and consultation will advise the adaptations to the current context.
5. Assess the impact of interventions- as above, continuing evaluation of client improvement on several dimensions with standardized instruments will inform personal impact and across participants indicate programmatic impact.

Reasons for selecting the milestones and metrics

DY2 and DY3 Process Milestones enable the project start-up P-2 and P-4. DY 4 and 5 Milestones (I-5) will reveal the functional changes that have occurred via the intervention. These functional improvements will be tracked by ANSA which by the start-up of the program will be the assessment instrument used for all Texas adults with SMI. This will provide comparative data to individual baseline to inform the program across each group at four points. The Individual electronic medical record will be used to track compliance with taking prescribed antipsychotic medications (I-3) of participants over the year of participation. Improvements will also be scored on CET internal instruments.

Unique community need identification number the project addresses:

CN.5 Behavioral Health – Data sources for the RHP 9 CNA provide an account of the limitations in services of the present state funded system for individuals with SMI (CN.8). CET will also help to reduce the use of the Emergency Departments and Readmissions (CN.12).

Related Category 3 Outcome Measure(s):

OD- 6 Patient Satisfaction was chosen as the Outcome Domain for the project with IT-6.1 as the Improvement Targets. LRMHMRC will employ the validated instrument Mental Health Statistics Improvement Program Consumer Survey (MHSIP). The MHSIP (developed by CMHS and SAMHSA for community MH block grant requirements) provides a standard instrument and protocol for data collection and processing and is seen as an outpatient mental health equivalent to the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS). Patient satisfaction is a fundamental way to ensure that LRMHMRC is meeting the needs of the SMI population in their integrated care. It will inform the PDSA process for continued improvement. The initial preparations for the project with health data collection on service participants to profile baseline function will be used to determine other outcome targets related to the health and risk statistics of individual participants and the population in the clinics.

Relationship to other Projects

The LRMHMRC Tele-Medicine Project (121988304.1.2 Introduce, Expand or Enhance Telemedicine / Telehealth) will allow coverage of individual support and coaching from other clinic sites for coverage during trainer absences as well as collaboration and consultation.

Related Category 4 Population-focused improvements: N/A

Relationship to Other Performing Providers' Projects in the RHP

A few other providers are proposing similar projects hopefully reducing hospital emergency department use for behavioral crisis but are doing so in other counties. The target group for these other projects does not overlap with the area served by LRMHMRC. However, LRMHMRC will seek to share experiences in approach and lessons learned within the region toward discovering best practices.

We plan to play an active role in development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV-Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with outcomes of this project to obtain additional perspectives that enable us to improve this project. The exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation:

This valuation used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided). The proposed program's value is based on a value per QALY gained due to the intervention multiplied by number of participants. (Eichler, H. G., et al. (2004). "Use of cost-effectiveness analysis in health-care resource allocation decision-making: how are cost-effectiveness thresholds expected to emerge?" Value Health 7(5): 518-528.; http://download.journals.elsevierhealth.com/pdfs/journals/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7

A description of the method used, titled 'Valuing Transformation Projects'. A complete write-up of the project will be available at performing provider site.

Total Valuation: $3,490,488

References:

1) National Instituted on Mental Health Grant MH-30750, results published in *The Archives of General Psychiatry,* 2004.
2) Hogerty, G., Greenwald, D.,*Cognitive Enhancement Training: The Training Manual,* 2006.
3) Hogarty, G. E. and Flesher, S., Practice Principles of Cognitive Enhancement Therapy for Schizophrenia. *Schizophrenia Bulletin,* 25(4): 693-708, 1999.
4) Eack, S. M., Hogarty, G. E., Greenwald, D. P., Hogarty, S. S. and Keshavan, M. S., Effects of Cognitive Enhancement Therapy on Employment Outcomes in Early Schizophrenia: Results From a 2-Yeal Randomized Trial, *Research on Social Work Practice*, 21(1):32-42, 2011.
5) Hogarty, G., Greenwald, D. and Eack, S., Durability and Mechanism of Errects of Cognitive Enhancement Therapy, *Psychiatric Services,* sp.psychiatryonline, 57(12), 1751-1757, 2006.

6) Green, R. S. & Newman, F. L., The Final Report of the Mental Health Statistics Improvement Program (MHSIP), Task Force on a Consumer-Oriented Mental Health Report Card, SAMHSA, CMHS, April,1996.

121988304.2.1	*Project Option: 2.13.1*	*Project Components: 2.13.1 (A-E)*	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting (Cognitive Enhancement Therapy)
Lakes Regional MHMR Center			*121988304*
Related Category 3 Outcome Measures:	121988304.3.3	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-2]: Design community-based specialized interventions for target populations. **Metric 1 P-2.1** [Project plans which are based on evidence / experience and which address the project goals] **Baseline/Goal:** Prepare plan including consultation, hiring staff, training, location, equipping program, inclusion criteria, collecting baseline data, choosing initial participants **Data Source**: Program documentation Milestone 1 Estimated Incentive Payment: **$415,785** **Process Milestone 2 [P-4]:** Evaluate and continuously improve interventions. **Metric 2 P-4.1:** [Project planning and implementation documentation	**Milestone 3** [P-X]: Survey population, select initial group, perform pre-intervention assessment, launch 48 week program. **Metric: 3** [P-X]: Participants screened and selected. Program operational. **Goals**: Baseline data on initial group of 8-12 participants collected and program start-up. **Data Source**: Schedules and EMR. Program documentation. Milestone 3 Estimated Incentive Payment: $**430,886** **Milestone 4** [P-X]: Survey population, select second ~~semi-annual~~ group, perform pre-intervention assessment, launch 48 week program. **Metric: 4** [P-X]: Participants for second group screened and selected. Program operational. **Goals**: Baseline data on second group of 8-12 participants collected and	**Milestone 5** [I-5]: Functional Status **Metric 5 [I-5.1]:** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. N=minimum 20. **Goals:** 60% of participants will demonstrate improvement in functional status on the ANSA over the course of the intervention. **Data Source:** EMR, Program reports. Milestone 5 Estimated Incentive Payment: **$458,056** **Milestone 6** [I-3]: Adherence to Antipsychotics for Individuals with Schizophrenia **Metric 6 [I-3.1]:** The percentage of individuals with schizophrenia like condition receiving specialized interventions who are prescribed an antipsychotic medication that had a Proportion of Days Covered (PDC) for antipsychotic medications greater than or equal to 0.8 during the	**Milestone 7** [I-5]: Functional Status **Metric 7 [I-5.1]:** The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. N=minimum 40. **Goals:** 60% of participants will demonstrate improvement in functional status on the ANSA over the course of the intervention. **Data Source:** EMR, Program reports. Milestone 7 Estimated Incentive Payment: $**440,516** **Milestone 8** [I-3]: Adherence to Antipsychotics for Individuals with Schizophrenia **Metric 8 [I-3.1]:** The percentage of individuals with schizophrenia like condition receiving specialized interventions who are prescribed an antipsychotic medication that had a Proportion of Days Covered (PDC) for antipsychotic medications greater than or equal to 0.8 during the

121988304.2.1	*Project Option: 2.13.1*	*Project Components: 2.13.1 (A-E)*	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting (Cognitive Enhancement Therapy)
Lakes Regional MHMR Center			*121988304*
Related Category 3 Outcome Measures:	121988304.3.3	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)**
demonstrates plan, do, study, act quality improvement cycles]. **Goals:** Close attention of a project team to argyle development and operations improvements. **Data Source:** Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment: **$415,785**	program start-up. **Data Source**: Schedules and EMR. Program documentation. Milestone 4 Estimated Incentive Payment: $**430,887**	measurement period (12 consecutive months). N=minimum 30. **Goals:** 70% of participants will meet the PDC target during participation in the program. **Data Source:** EMR, program documents Milestone 6 Estimated Incentive Payment: **$458,057**	measurement period (12 consecutive months). N=minimum 60. **Goals:** 70% of participants will meet the PDC target during participation in the program. **Data Source:** EMR, program documents Milestone 8 Estimated Incentive Payment: $**440,516**
Year 2 Estimated Milestone Bundle Amount: **$831,570**	Year 3 Estimated Milestone Bundle Amount: **$861,773**	Year 4 Estimated Milestone Bundle Amount: **$916,113**	Year 5 Estimated Milestone Bundle Amount: **$881,032**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: ***$3,490,488***			

Project Option 2.4.1-Implement a strategic improvement program for patient satisfaction (Redesign to Improve Patient Experience)

Unique Project ID: 020979301.2.1
Performing Provider Name/TPI: Las Colinas Medical Center/ 020979301

Provider: Las Colinas Medical Center is a 100-bed acute care hospital in Dallas County, Texas serving a primary and secondary service population of approximately 800,000.

Intervention(s): This project will create workgroups under a steering committee to implement improvement work on patient experience targets. The goal is to have multiple process improvement events each year from DY 3 through DY 5, at least 2 per year to streamline processes that are not resulting in optimal patient experiences as part of continuous quality improvement. At DY 4 and DY 5, we have routine, formalize updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families with organizational displays. We expect in DY 4 there are 7 such updates and DY 5, 15 updates.

Need for the project: We currently are below the 75% percentile in Grand Composite Scores for HCAHPS survey. Key scores are include communication with nurses and doctor and communication regarding medications. Effective communication is critical for patient safety and quality of care of patients. Improvement efforts have not made material improvement in score in past 4 quarters.

Target population: The target population is IP, ED and OP patients at the hospital. Approximately 23% of our patients are either Medicaid eligible or indigent. We estimate 5,000 patients a year or 22,500 over the course of the waiver will be impacted. We do actively survey 100 patients a month/1200 a year

Category 1 or 2 expected patient benefits: The project seeks to improvement in patient satisfaction scores as measured by HCAHPS Grand CompositeScores. . This will be a benefit to patients from better communication with nurses and doctors , better medication management, pain management and discharge planning. Studies have shown with improved patient experience, the quality of care patients experience also improves. This will result in reduce preventable complications such as infections, less readmissions and reduced medication errors. It is estimated patients impacted will be DY 2-5,299, DY 3-5,564, DY 4-5,731, DY5-5,903.

Category 3 outcomes: IT-6.1 Our goal is to improve Percent Improvement over baseline of patient satisfaction scores from 71% currently to 85% by DY5, a 20% improvement..

Project Description

Las Colinas Medical Center is proposing a project to establish baseline Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores and implement a patient/family experience strategic plan.

A steering committee will be formed and workgroups of the committee will work on process improvements for patient experience targets. Evaluation will be performed and documented to measure implementation progress, results and make adjustments to improvement plans. As part of the strategic plan, patient experience will be an integral part of employee orientation. A communication plan on work being done to improve the patient experience will be developed and implemented to ensure all employees and physicians are included on progress and initiatives. Studies have shown that improved patient experience can improve patient health outcome and quality.

Goals and Relationship to Regional Goals

The goal of the project is to implement process improvement plans that target specific patient experiences. The purpose of performing this project is the engage all stakeholder such as leader and employees that can be the high level role to drive the patient experience improvement across the hospital for a cultural change at the organizational level.

A major goal of the region is to pursue the triple aim of healthcare by improving patient experience of care, improve health of populations and reduce the cost of healthcare. Redesigning the patient experience at the in the region will impact the health of our community by keeping patients engaged in the healthcare system.

Challenges

The hospital has been participating in HCAHPS to measure patient experience in hospital setting. Implemented training plans have not improved scores. Las Colinas Medical Center has achieved Grand Composite score of 71% for 2010 Q3-2011 Q2 and 71% for 2010 Q4-2011Q3, which is consistently been below the CMS National Average. The scores summarize:

- how well nurses and doctors communicate with patients
- how responsive hospital staff are to patients' needs
- how well hospital staff help patients manage pain
- how well the staff communicates with patients about medicines, and whether key information is provided at discharge
- cleanliness and quietness of patients' rooms
- patients' overall rating of the hospital and whether patients' would recommend the hospital to family and friends

The project will address targeted patient experiences with that have not been improved by other initiatives.

5-Year Expected Outcome for Provider and Patients

We expected at end of waiver period we will be > 75th percentile on Grand Composite scores for CMS HCAHPS. The hospital will have improved processes for service that will increase quality and safety of care.

Starting Pointe/Baseline

Las Colinas Medical Center has achieved Grand Composite scores of 71% in 2010 Q3-2011 Q2 and 71% 2010 Q4-2011 Q3, which has consistently been below the CMS National Average.

Rationale

Patient experience scores are measured internally and reported quarterly from a Gallup Survey. These scores are shared with senior leaders and staff in various manners including Dashboards and reports. Various committees work on departmental and process issues but a coordinated, system wide approach is lacking. A patient/family experience strategic plan will eliminate duplication of time and effort and provide a roadmap for improvement and best practice. Engaging patients and families in the process will strengthen the organization's resolve to get better and stay better

The overall approach to redesigning patient experience will be centered on cultural change at the organizational level. This will involve clinicians, patients and their families or caregivers. An organizational strategy will be developed so that we manage patient experience and create avenues to implement the strategic plan/vision. This project option is best for organizational integration which is critical to successful patient experiences.

Project Components

All core components will be implemented:

a) Organizational integration and prioritization of patient experience
b) Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience;
c) Implementing processes to improve patient's experience in getting through to the clinical practice;
d) Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures.

Establishing a steering committee with high level leadership is necessary to drive cultural change to impact patient experiences. A communication plan will be developed to inform all employees and physicians of the work of the steering committee and results to better integrate the process and changes into the culture. Process improvements needed will be identified and analyzed with Lean Six Sigma tools. The work groups will be empowered to implement changes identified and report back to the steering committee. To sustain results of changes implemented, audits at 6 months and 12 months will be utilized for each process improvement event. Evaluation, control and sustain activities are necessary for continuous quality improvements. The goal is to have multiple improvement events each year, at least 2 per year. We will measure the impact of the improvements implemented from CMS HCAHPS scores.

Unique Community Need Identification Numbers the Project Addresses

CN.11: Patient Safety and Quality

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

This is a new initiative for Las Colinas Medical Center. It currently does not have the structure or feedback mechanism this program will implement for patient experience improvement.

Related Category 3 Outcome Measure(s)

IT-6.1: Percent improvement over baseline of patient satisfaction scores will be the focus of the patient satisfaction improvement plan.

An organizational strategy will be developed so that the hospital will better manage patient experiences and create avenues to implement the strategic plan/vision. Performance will be measured, among other factors, by the extent to which patient experience improves systematically.

In October 2005, the Joint Commission's Journal on Quality and Patient Safety published a series of case studies of healthcare institutions' efforts to improve both quality and safety. One of these was from Lehigh Valley Hospital in Allentown, Pennsylvania, which used active engagement of patients and families in attempting to improve patient safety. Anthony, R., Ritter M., Davis, R., Hitchings, K., Capuano, T. A., &Mawji, Z. (2005, October). Lehigh Valley Hospital: engaging patients and families. Joint Commission Journal on Quality and Patient Safety, 31(10), 566-572.

Weingart and colleagues (2006) examined inpatients' reports of service "incidents" — deficiencies in service quality such as waits/delays, poor communication, poor care coordination, lack of respect for personal preferences, or environmental issues. They found that roughly 40% of patients reported at least one incident and that reporting of incidents was

associated with diminished patient satisfaction. Weingart, S. N., Pagoviceh, O., Sands, D. Z., Li, J. M., Aronson, M. D., Davis, R. B., Phillips, R. S., & Bates, D. W. (2006, April). Patient-reported service quality on a medicine unit. International Journal of Quality in Health Care, 18(2), 95-101

Also, Kaldenberg and Trucano (2007) examined facility-level relationships between hospital-acquired infection (HAI) rates and patient perceptions of specific aspects of hospital quality in the State of Pennsylvania. Specifically, they chose three questions from an inpatient survey thought to measure practices that, when poorly executed, could create a more infection-prone environment: ratings of cleanliness; of the skill of the person who took the patient's blood; and of nurses' response to the call button. All three were found to be significantly, negatively correlated with HAI rates. Kaldenberg, D. & Trucano, M. (2007, August 22). The relationship between patient perceptions of hospital practices and facility infection rates: Evidence from Pennsylvania hospitals. Patient Safety & Quality Healthcare

Relationship to other projects

This project is to redesign to improve the patient experience. This project supports 020979301.4.3 RD-2 Potentially Preventable Readmissions- 30 days and 020979301.4.4 RD -3 Potentially Preventable Complications. An improved patient experience has been shown to correlate to improved quality of care and safety. This project also support 020979301.4.5 RD-4 Patient-centered healthcare. The project will implement training and improvement work on experience targets aimed to increasing patient satisfaction with the hospital, nurses and physicians that will result in a better patient experience.

Relationship to other Performing Providers' projects and Plan for Learning Collaborative

The following providers are also proposing projects to Redesign to Improve Patient Experience:

- Denton Regional Medical Center: 111905902.2.2
- Medical Center of Lewisville: 094192402.2.1

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology:

Las Colinas Medical Center defined the population that will be directly impacted by the project as patients with Medicare and all patients who are the target of HCAHPS survey. The percentage of the population expected to be positively impacted by the project is all patients

surveyed, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed to determine the value to the health care system for each positive outcome realized as the result of our project. It was estimated based on CMS published penalties that in 5 years for not achieving satisfactory patient experience levels, 1.5% of Medicare revenues were in jeopardy. The Medicare average volume per year of 800 cases and rate per Medicare case of $8,654 was used to calculate the estimated loss of revenues using these penalty % for DY 2- 0.50%, DY 3- 0.75%, DY 4-0.94%, and DY5 -1.5% . This totaled $356,500 for a 5 year period.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, patient experience improves, which results from improved safety and quality of care that better health outcomes and reduced costs. This was estimated a portion of potential revenue value and totaled $260,245 . To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, his or quality of life is improved, productivity is increased, and there is a reduced burden on society. This was estimated a portion of potential revenue value and totaled $ 214,303.

The total value of the project was calculated at $831,048. Approximately 79% of the project value was assigned to the Category 2 project, $657,118 and 21% to the Category 3 project, $173,930.

Rationale/Justification:. The economic value of each targeted improvement outcome from evidence based studies was used a guide for the overall value of project. Additional value was considered for resource investments needed, timelines, cost avoidance, and risk and project scope.

020979301.2.1	***2.4.1***	***2.4.1 (A-D)***	***IMPLEMENT A STRATEGIC IMPROVEMENT PROGRAM FOR PATIENT SATISFACTION (REDESIGN TO IMPROVE PATIENT EXPERIENCE)***	
Las Colinas Medical Center				*20979301*
Related Category 3 Outcome Measure(s):	*020979301.3.1*	*3 IT 6.1*	*Percent Improvement over baseline of patient satisfaction scores (all 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-3]: Establish steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient and/or employee experience. Steering committee should meet at least twice a month. Metric 1 [P-3.1]**:** Documentation of committee proceedings and list of committee Members. Baseline/Goal: Establish committee and meeting schedule Data Source: Meeting minutes, agendas, participant lists, and/or list of steering committee members Milestone 1 Estimated Incentive Payment:$81,845 **Milestone 2** [P-2]: Write and disseminate a patient/family experience strategic plan Metric 1 [P-2.1]: Submission of a strategic plan and documentation of the dissemination of that plan throughout the organization	**Milestone 3** [P-11]: 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, noise levels and/or dining experience; better ambulatory experience; improved employee experience, etc.). Workgroups should be formed under the steering committee to work on experience targets. Detailed implementation plans should be created for each workgroup. Metric 1 [P-11.1]: Submission of implementation plan. Goal: Implement Data Source Implementation plan Milestone 3 Estimated Incentive Payment *(maximum amount):*$55,674 **Milestone 4 [**P-13]: Perform a mid-course evaluation of the results of improvement projects / Make necessary adjustments and continue with implementation		**Milestone 6** [I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families. Metric 1 [I-18.1]: Number of organization-wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: 7 displays Data Source: Verification of displays, methodology and CEO report to employees, physicians and steering committee Milestone 6 Estimated Incentive Payment *(maximum amount):* $178,659	**Milestone 7** [I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families. Metric 1 [I-18.1]: Number of organization-wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: 15 displays Data Source: Verification of displays, methodology and CEO report to employees, physicians and steering committee Milestone 7 Estimated Incentive Payment: $147,746

020979301.2.1	***2.4.1***	***2.4.1 (A-D)***	***IMPLEMENT A STRATEGIC IMPROVEMENT PROGRAM FOR PATIENT SATISFACTION (REDESIGN TO IMPROVE PATIENT EXPERIENCE)***	
Las Colinas Medical Center				*20979301*
Related Category 3 Outcome Measure(s):	*020979301.3.1*	*3 IT 6.1*	*Percent Improvement over baseline of patient satisfaction scores (all 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)**
Goal: Documented patient experience plan and communication strategies well defined Data Source: Completed patient experience plan, verification of communication throughout the organization. Milestone 2 Estimated Incentive Payment *(maximum amount):* $81,846	Metric 1 [P-13.1]*:* Submission of evaluation results. Goal: Evaluate 100% of improvement projects Data Source: Evaluation write –up Milestone 4 Estimated Incentive Payment: $55,674 **Milestone 5** [P-4]: Integrate patient experience into employee training. Metric 1 [P-4.1]: 100 % of new employees who received patient experience training as part of their new employee orientation. Goal: Develop training Data Source:Implementation plan Milestone 5 Estimated Incentive Payment *(maximum amount):* $55,674			
Year 2 Estimated Milestone Bundle Amount: $163,691	Year 3 Estimated Milestone Bundle Amount: $167,022		Year 4 Estimated Milestone Bundle Amount: $178,659	Year 5 Estimated Milestone Bundle Amount: $147,746
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $657,118				

Project Option 2.4.1-Implement a strategic improvement program for patient satisfaction (Redesign to Improve Patient Experience)

Unique Project ID: 094192402.2.1
Performing Provider Name/TPI: Medical Center of Lewisville/094192402

Provider: Medical Center of Lewisville is a 166-bed acute care hospital in Denton County, Texas serving a primary and secondary service population of approximately 350,000.

Intervention(s): This project will create workgroups under a steering committee to implement improvement work on patient experience targets. The goal is to have multiple process improvement events each year from DY 3 through DY 5, at least 2 per year to streamline processes that are not resulting in optimal patient experiences as part of continuous quality improvement. At DY 4 and DY 5, we have routine, formalize updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families with organizational displays. We expect in DY 4 there are 7 such updates and DY 5, 10 updates.

Need for the project: We currently are below the 75% percentile in Grand Composite Scores for HCAHPS survey. Key scores are include communication with nurses and doctor and communication regarding medications. Effective communication is critical for patient safety and quality of care of patients. Improvement efforts have not made material improvement in score in past 4 quarters.

Target population: The target population is IP, ED and OP patients at the hospital. Approximately 36% of our patients are either Medicaid eligible or indigent. . We estimate an average of 7,600 patients a year or 40,600 over the course of the waiver will be impacted. We do actively survey 100 patients a month/1200 a year

Category 1 or 2 expected patient benefits: The project seeks to improvement in patient satisfaction scores as measured by HCAHPS Grand Composite Scores This will be a benefit to patients from better communication with nurses and doctors , better medication management, pain management and discharge planning. Studies have shown with improved patient experience, the quality of care patients experience also improves. This will result in reduce preventable complications such as infections, less readmissions and reduced medication errors. It is estimated patients impacted will be DY1-7,647, DY 2-7,877, DY 3-8,113, DY 4-8,356, DY5-8,607.

Category 3 outcomes: IT-6.1 Our goal is to improve Percent Improvement over baseline of patient satisfaction scores from 70% currently to 84% by DY5, for a 20% improvement

Project Description

Medical Center of Lewisville is proposing a project to establish baseline Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores and implement a patient/family experience strategic plan.

A steering committee will be formed and workgroups of the committee will work on process improvements for patient experience targets. Evaluation will be performed and documented to measure implementation progress, results and make adjustments to improvement plans. As part of the strategic plan, patient experience will be an integral part of employee orientation. A communication plan on work being done to improve the patient experience will be developed and implemented to ensure all employees and physicians are included on progress and initiatives. Studies have shown that improved patient experience can improve patient health outcome and quality.

Goals and Relationship to Regional Goals:

The goal of the project is to implement process improvement plans that target specific patient experiences. The purpose of performing this project is the engage all stakeholder such as leader and employees that can be the high level role to drive the patient experience improvement across the hospital for a cultural change at the organizational level

A major goal of the region is to pursue the triple aim of healthcare by improving patient experience of care, improve health of populations and reduce the cost of healthcare. Redesigning the patient experience at the in the region will impact the health of our community by keeping patients engaged in the healthcare system.

Challenges

The hospital has been participating in HCAHPS to measure patient experiences in a hospital setting. Implemented training plans have not improved scores. Medical Center of Lewisville has achieved Grand Composite score of 70% for 2010 Q3-2011 Q2 and 70% for 2010 Q4-2011Q3, which is consistently been below the CMS National Average. The scores summarize:

- how well nurses and doctors communicate with patients
- how responsive hospital staff are to patients' needs
- how well hospital staff help patients manage pain
- how well the staff communicates with patients about medicines, and whether key information is provided at discharge
- cleanliness and quietness of patients' rooms
- patients' overall rating of the hospital and whether patients' would recommend the hospital to family and friends

The project will address targeted patient experiences with that have not been improved by other initiatives.

5-Year Expected Outcome for Provider and Patients

We expect at end of waiver period we will be > 75th percentile on Grand Composite scores for CMS HCAHPS. The hospital will have improved processes for service that will increase quality and safety of care.

Starting Point/Baseline

Medical Center of Lewisville has achieved Grand Composite scores of 70% in 2010 Q3-2011 Q2 and 70% 2010 Q4-2011 Q3, which has consistently been below the CMS National Average.

Rationale

Patient experience scores are measured internally and reported quarterly from a Gallup Survey. These scores are shared with senior leaders and staff in various manners including Dashboards and reports. Various committees work on departmental and process issues but a coordinated, system wide approach is lacking. A patient/family experience strategic plan will eliminate duplication of time and effort and provide a roadmap for improvement and best practice. Engaging patients and families in the process will strengthen the organization's resolve to get better and stay better

The overall approach to redesigning patient experience will be centered on cultural change at the organizational level. This will involve clinicians, patients and their families or caregivers. An organizational strategy will be developed so that we manage patient experience and create avenues to implement the strategic plan/vision. This project option is best for organizational integration which is critical to successful patient experiences.

Project Components

All core components will be implemented:

a. Organizational integration and prioritization of patient experience
b. Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience;
c. Implementing processes to improve patient's experience in getting through to the clinical practice;

d. Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures.

Establishing a steering committee with high level leadership is necessary to drive cultural change to impact patient experiences. A communication plan will be developed to inform all employees and physicians of the work of the steering committee and results to better integrate the process and changes into the culture. Process improvements needed will be identified and analyzed with Lean Six Sigma tools. The work groups will be empowered to implement changes identified and report back to the steering committee. To sustain results of changes implemented, audits at 6 months and 12 months will be utilized for each process improvement event. Evaluation, control and sustain activities are necessary for continuous quality improvements. The goal is to have multiple improvement events each year, at least 2 per year. We will measure the impact of the improvements implemented from CMS HCAHPS scores.

Unique Community Need Identification Numbers the Project Addresses

CN.11: Patient Safety and Quality

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

This is a new initiative for Medical Center of Lewisville. It currently does not have the structure or feedback this program will implement for patient experience improvement,

Related Category 3 Outcome Measure(s)

IT-6.1: Percent improvement over baseline of patient satisfaction scores will be the focus of the patient satisfaction improvement plan.

An organizational strategy will be developed so that the hospital will better manage patient experiences and create avenues to implement the strategic plan/vision. Performance will be measured, among other factors, by the extent to which patient experience improves systematically.

In October 2005, the Joint Commission's Journal on Quality and Patient Safety published a series of case studies of healthcare institutions' efforts to improve both quality and safety. One of these was from Lehigh Valley Hospital in Allentown, Pennsylvania, which used active engagement of patients and families in attempting to improve patient safety. Anthony, R., Ritter M., Davis, R., Hitchings, K., Capuano, T. A., &Mawji, Z. (2005, October). Lehigh Valley Hospital: engaging patients and families. Joint Commission Journal on Quality and Patient Safety, 31(10), 566-572.

Weingart and colleagues (2006) examined inpatients' reports of service "incidents" — deficiencies in service quality such as waits/delays, poor communication, poor care coordination, lack of respect for personal preferences, or environmental issues. They found that roughly 40% of patients reported at least one incident and that reporting of incidents was associated with diminished patient satisfaction. Weingart, S. N., Pagoviceh, O., Sands, D. Z., Li, J. M., Aronson, M. D., Davis, R. B., Phillips, R. S., & Bates, D. W. (2006, April). Patient-reported service quality on a medicine unit. International Journal of Quality in Health Care, 18(2), 95-101

Also, Kaldenberg and Trucano (2007) examined facility-level relationships between hospital-acquired infection (HAI) rates and patient perceptions of specific aspects of hospital quality in the State of Pennsylvania. Specifically, they chose three questions from an inpatient survey thought to measure practices that, when poorly executed, could create a more infection-prone environment: ratings of cleanliness; of the skill of the person who took the patient's blood; and of nurses' response to the call button. All three were found to be significantly, negatively correlated with HAI rates. Kaldenberg, D. & Trucano, M. (2007, August 22). The relationship between patient perceptions of hospital practices and facility infection rates: Evidence from Pennsylvania hospitals. Patient Safety & Quality Healthcare

Relationship to other projects

This project is to redesign to improve the patient experience. This project supports 094192402.4.3 RD-2 Potentially Preventable Readmissions- 30 days and 094192402.4.4 RD -3 Potentially Preventable Complications. An improved patient experience has been shown to correlate to improved quality of care and safety. This project also support 094192492.4.5 RD-4 Patient-centered healthcare. The project will implement training and improvement work on experience targets aimed to increasing patient satisfaction with the hospital, nurses and physicians that will result in a better patient experience.

Relationship to other Performing Providers' projects and Plan for Learning Collaborative

The following providers are also proposing projects to Redesign to Improve Patient Experience:

Denton Regional Medical Center:	111905902.2.2
Las Colinas Medical Center:	020979301.2.1

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology:
Medical Center of Lewisville defined the population that will be directly impacted by the project as patients with Medicare and all patients who are the target of HCAHPS survey. The percentage of the population expected to be positively impacted by the project is all patients surveyed, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed to determine the value to the health care system for each positive outcome realized as the result of our project. It was estimated based on CMS published penalties that in 5 years for not achieving satisfactory patient experience levels, 1.5% of Medicare revenues were in jeopardy. The Medicare average volume per year of 2,150 cases and rate per Medicare case of $8,634 was used to calculate the estimated loss of revenues using these penalty % for DY 2- 0.50%, DY 3- 0.75%, DY 4-0.94%, and DY5 -1.5% . This totaled $771,480 for a 5 year period.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, patient experience improves, which results from improved safety and quality of care that better health outcomes and reduced costs. This was estimated a portion of potential revenue value and totaled $154,296. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, his or quality of life is improved, productivity is increased, and there is a reduced burden on society. This was estimated a portion of potential revenue value and totaled $ 149,195.

The total value of the project was calculated at $1,074,974. Approximately 79% of the project value was assigned to the Category 2 project, $849,981 and 21% to the Category 3 project, $224,900.

Rationale/Justification:

The economic value of each targeted improvement outcome from evidence based studies was used a guide for the overall value of project. Additional value was considered for resource investments needed, timelines, cost avoidance, and risk and project scope.

094192402.2.1	***2.4.1***	***2.4.1 (A-D)***	***IMPLEMENT A STRATEGIC IMPROVEMENT PROGRAM FOR PATIENT SATISFACTION (REDESIGN TO IMPROVE PATIENT EXPERIENCE)***	
Medical Center of Lewisville				*94192402*
Related Category 3 Outcome Measure(s):	*094192402.3.1*	*3 IT 6.1*	*Percent Improvement over baseline of patient satisfaction scores (all 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-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 should meet at least twice a month. Metric 1 [P-3.1]**:** Documentation of committee proceedings and list of committee Members. Baseline/Goal: Establish committee and meeting schedule Data Source: Meeting minutes, agendas, participant lists, and/or list of steering committee members Milestone 1 Estimated Incentive Payment *(maximum amount):*$105,700 **Milestone 2** [P-2]: Write and disseminate a patient/family experience strategic plan Metric 1 [P-2.1]: Submission of a strategic plan and documentation of the dissemination of that plan	**Milestone 3** [P-11]: 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, noise levels and/or dining experience; better ambulatory experience; improved employee experience, etc.). Workgroups should be formed under the steering committee to work on experience targets. Detailed implementation plans should be created for each workgroup. Metric 1 [P-11.1]: Submission of implementation plan. Goal: Implement Data Source: Implementation plan Milestone 3 Estimated Incentive Payment *(maximum amount):*$72,071 **Milestone 4 [**P-13]: Perform a mid-course evaluation of the results of improvement projects / Make necessary adjustments and	**Milestone 6** [I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families. Metric 1 [I-18.1]: Number of organization-wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: 7 displays Data Source: Verification of displays, methodology and CEO report to employees, physicians and steering committee Milestone 6 Estimated Incentive Payment *(maximum amount):* $231,296	**Milestone 7** [I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families. Metric 1 [I-18.1]: Number of organization-wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: 10 displays Data Source: Verification of displays, methodology and CEO report to employees, physicians and steering committee Milestone 7 Estimated Incentive Payment: $191,071

094192402.2.1	***2.4.1***	***2.4.1 (A-D)***	***IMPLEMENT A STRATEGIC IMPROVEMENT PROGRAM FOR PATIENT SATISFACTION (REDESIGN TO IMPROVE PATIENT EXPERIENCE)***	
Medical Center of Lewisville				*94192402*
Related Category 3 Outcome Measure(s):	*094192402.3.1*	*3 IT 6.1*	*Percent Improvement over baseline of patient satisfaction scores (all 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)**
throughout the organization Goal: Documented patient experience plan and communication strategies well defined Data Source: Completed patient experience plan, verification of communication throughout the organization. Milestone 2 Estimated Incentive Payment *(maximum amount):* $105,700	continue with implementation Metric 1 [P-13.1]*:* Submission of evaluation results. Goal: Evaluate 100% of improvement projects Data Source: Evaluation write –up Milestone 4 Estimated Incentive Payment: $72,071 **Milestone 5** [P-4]: Integrate patient experience into employee training. Metric 1 [P-4.1]: 100 % of new employees who received patient experience training as part of their new employee orientation. Goal: Develop training Data Source: Implementation plans Milestone 5 Estimated Incentive Payment *(maximum amount):* $72,072		
Year 2 Estimated Milestone Bundle Amount: $211,400	Year 3 Estimated Milestone Bundle Amount: $216,214	Year 4 Estimated Milestone Bundle Amount: $231,296	Year 5 Estimated Milestone Bundle Amount: $191,071
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $849,981			

Projection Option 2.8.11- Implement an Innovative and Evidence Based Intervention that will lead to reduction in Sepsis Complications (Apply Process Improvement Methodology to Improve Quality/Efficiency)

Unique Project ID: 094192402.2.2
Performing Provider Name/TPI: Medical Center of Lewisville/ 94192402

Provider: Medical Center of Lewisville is a 166-bed acute care hospital in Denton County, Texas serving a primary and secondary service population of approximately 340,000.

Intervention(s): This project will implement process improvement methodologies in a sepsis evidenced based care program to reduce sepsis complications. . Interventions will include implementing houseiwde 12/hour screenings on all patients, ED protocols, ICU Sepsis evidence based care treatment protocols and developing a measurement and reporitng system.

Need for the project: The current diagnosis and treatment of sepsis is not adequate for patient safety and quality of care with mortality as high as 60 % . Complications from lack of timely and appropriate treatment of sepsis including lifetime health issues, disability and mortality puts an unnecessary burden on society and the healthcare system. Process improvement methodologies will facilitate analysis of the evidence based program and implementation of corrective actions to improve implementation and maximize outcomes.

Target population: The target population for diagnosing sepsis arepatients presenting to ED and all patients in house. . By initiating housewide screening every 12 hours on patients , we believe the number of patients diagnosed will increase. Once diagnosed with sepsis hock, severe sepsis, evidence based treatment is necessary. Approximately 49% of patients to be screened are Medicaid and indigent. It is estimated currently 20% of our patients screened and treated for sepsis are Medicaid eligible or indigent. Based on current processes over 465 patients will be treated over course of the waiver, however with improvement in diagnosis a key element of the program, this number is expected to increase to estimated 647 patients over 5 years (DY1-93, DY2-112, DY3-134, DY4-154, DY5-154).Patients who are Medicaid eligible or uninsured will benefit as they more often use the ED and their illness is farther progressed when presenting to ED along with greater complexity of co-morbid diseases. Due to lack of access to medical care patients tend to delay seeking care which can lead to harmful results. The quicker diagnosis of sepsis and evidence-based care will prevent greater mortality and disability from sepsis.

Category 1 or 2 expected patient benefits: The project seeks to increase the timeliness of correctly diagnosing sepsis in order the begin evidence based care with improve the compliance with Sepsis Bundle and Resuscitation for patients diagnosed with septic shock. We expect to diagnose and treat 647 sepsis patients (estimated at DY 1- 93, DY2-112, DY 3- 134, DY 4- 154,

DY 5-154). 93 patients were diagnosed in DY 1 with the implementation of the sepsis program. However only 81 patients were properly treated with the evidence based care plan from the program. In addition it is estimated based on similar size hospitals with sepsis programs, we should expect to diagnosis 154 patients a year. Potentially we are not properly diagnosing 61 patients a year. Patients that may not diagnosed/diagnosed timely or not receive evidence based treatment may have resulted in death or disability. The program will have great benefit to patients to reduce harm from lack of proper and timely diagnosis and/or lack of evidence based treatment.

Category 3 outcomes: IT-4.8 Our goal is to reduce the Sepsis Mortality of patients diagnosed with sepsis from 30% currently to 20% by DY5. . The estimated DY 1 mortality was 20% and improvement of 20% by DY 5, morality would be 16%
IT -4.9 Our goal is the reduce the Average length of stay of patients with sepsis by 10% in DY 4 and 10 % in DY 5 for a 20% total reduction by DY 5. Estimated DY 1 ALOS was 7 , a reduction goal by DY 5 days to ALOS of 5.5.

Project Description

The project will design and implement a Process Improvement plan to increase the utilization and compliance with Sepsis Resuscitation and Management Bundles to improve patient outcomes.

Medical Center of Lewisville is committed to continuous quality improvement so all of our patients receive the safest and highest quality health care possible. We are implementing a standardized, evidence-based program for early detection and resuscitation of patients with severe sepsis and septic shock to reduce unnecessary death and harm attributable to sepsis. Our processes and interventions are based upon evidence-based care models, which include a sepsis resuscitation bundle for Emergency Department (ED) patients and a sepsis management bundle for ongoing care. Rapid diagnosis and management are cornerstones to successful outcomes.

The ICU and ED plans for improvements in sepsis identification and treatment includes, revising the electronic nurse sepsis screening at triage, implementing an electronic nurse sepsis screen to aid in early detection of inpatients, staff education regarding sepsis screening, and refining the Rapid Response Team (RRT) processes to include sepsis screening and initial resuscitation. This allows the RRT to begin fluid resuscitation on the in-house patient that screens positive for severe sepsis or septic shock and is hypotensive.

Medical Center of Lewisville will also track primary endpoints of mortality and ICU LOS. Process and other measures will be tracked that include, percentage of patients initiated on vasopressors and mean days of vasopressor use, percentage of patients initiated on the mechanical ventilator and mean ventilator days, and initiation of hemodialysis or continuous

renal replacement therapy. Our target population is any patient diagnosis of severe sepsis, septic shock, and/or lactate >4mmol/L (36mg/dl).

Although great work has been done to implement protocols and interventions, utilization and compliance of Sepsis Resuscitations and Management Bundles are still remains a challenge. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through multidisciplinary teams.

Goals and Relationship to Regional Goals:

The goal of this project is to implement Process Improvement plan to improve safety and quality for those patients with Sepsis. We will:

1) Achieve 95% Compliance with the Sepsis Resuscitation and Management Bundles in patients admitted to the ICU.
2) Substantially improve early sepsis identification, reduce sepsis related Mortality by 20% from baseline.
3) Effective and fully implemented measurement and reporting system supporting compliance with the Sepsis Resuscitation and Management Bundles.
4) Continue to work with Emergency Medical Services to improve the delivery of care provided to patients with suspected infection.
5) Improve identification of sepsis patients' house wide by implementing nursing admission screening and shift assessments for sepsis screening.
6) Improve identification of sepsis, compliance from TBD with current Sepsis Resuscitation and Management Bundles in the Emergency Department.

This project supports the regional goals to improve the patient care experience, health outcomes for the population and the per capita cost of care. Specifically, this project will improve the early diagnosis of patients with severe sepsis and septic shock so that evidence based care can be delivered. Improved recovery of patients with severe sepsis and septic shock will reduce unnecessary death and harm and reduce cost of post hospital care in addition to quality-adjusted life gained

Challenges

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. The eighth leading cause of death is influenza and pneumonia combined, and pneumonia is a leading source of severe sepsis and septic shock. Septicemia, influenza, and pneumonia deaths in 2007 contributed to over 80,000 deaths. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. In the United States, there are approximately 750,000 new cases of sepsis, which includes diagnoses of severe sepsis and septic shock, each year, and mortality from severe

sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Proactive analysis of the contributing factors contributing to the design of evidenced based standardized care sets and subsequent adoption of those tools will aid greatly to reducing variation and associated cost. Early recognition and management of sepsis results in lives saved.

5-Year Expected Outcome for Provider and Patients

We expect to reach 100% compliance in identification/diagnosing of patients with severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl). We also expect to be at 95% compliance with application of the Sepsis Bundles for patients that meet specified criteria.

Starting Point/Baseline

. The number of patients with severe sepsis, septic shock and/or lactate>4mmol/L (36mg/dl) that would qualify for sepsis resuscitation and management bundles based on expected sepsis claims from similar size hospital and mature sepsis programs would be 154 per year for a total of 647 patients over course of the waiver. The hospital only diagnosed 93 patients in DY 1. Of those patients diagnosed only 81 received evidenced based care for sepsis bundles. Active implementation of sepsis resuscitation and management bundles and data collection is beginning in 2012. Early data collection indicates compliance with sepsis bundles is a low as 79%.It is expected that the morality rate for this population in DY 2 will initially increase compared to DY 1 due to more patients being correctly diagnosed with new sepsis protocols thus a baseline will be established in DY2 to measure same mortality based on same standards of care. The same is true for average length of stay, although it may decrease rather than increase. A baseline in DY 2 is necessary to measure patients receiving the same protocol based diagnosis and standard of care.

Rationale

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. The eighth leading cause of death is influenza and pneumonia combined, and pneumonia is a leading source of severe sepsis and septic shock. Septicemia, influenza, and pneumonia deaths in 2007 contributed to over 80,000 deaths. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. In the United States, there are approximately 750,000 new cases of sepsis, which includes diagnoses of severe sepsis and septic shock, each year, and mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Project Options

Our internal data shows a mortality rate as high as 60%. Identification and treatment protocols have been developed and implemented to impact mortality and ICU LOS which has improved. Although program components have been implemented and put in place, we still face the challenge of successful implementation. Also, additional interventions will be implemented in the future (shift assessments on all in-house patients etc.). To be successful we need to work on processes that create time delays, non-adherence to order set and, failure to identify/diagnose sepsis. We are at 80% compliance in implementing Sepsis Bundles. We believe in order to continue to see improvement from initial implementation, continuous quality improvement through data collection, analysis and review will accelerate change through our multidisciplinary teams.

Project Components

The project components to report metrics for Sepsis Mortality and Average Length of Stay are necessary to measure the success of implementing the Sepsis Improvement Plan.

A Sepsis Improvement Plan must have key elements to be successful. A project plan is necessary to identify and engage all stakeholders (ED, Inpatient Units, and EMS etc), understand current status, resources, baselines, roles and responsibilities, expectations of individuals and outcomes. In order to have an impact on reduction in mortality and average length of stay compliance with Sepsis diagnosis and protocols for Sepsis Bundles are critical. In implementation of a plan, it is necessary to examine the plan as it is implemented, understand what is working and what is not, identify barriers and make corrective action. . Continuous quality improvement (CQI) activities will be conducted to ensure successful implementation. In DY2 and DY 3, milestones to implement a program to improve efficiencies and/or reduce program variation are essential to the success of sepsis program. The practice strategy for PDSA and CQI will be a Lean Six Sigma DMAIC approach. A Value Stream Mapping will allow us to document the current state of the program implemented in 2012. The Value Stream Mapping and metric results will determine where variation exits and which processes are constraints to the success of the program. This will help us identify the priority for processes improvement events to be conducted. The team will conduct events utilizing tools to find root causes of variations or process delays. Changes will be implemented with appropriate tools to update the program process. To sustain results of changes implemented, audits at 6 months and 12 months will be utilized for each process improvement event. Each year a Value Stream Mapping can be utilized to validate change, document current state and continue the cycle of process improvemen

Unique Community Need Identification Numbers the Project Addresses

This project addresses identification number CN.11 Patient Safety and Quality from the community needs assessment. The program will improve the health outcomes for patients diagnosed with severe sepsis or sepsis shock.

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

Sepsis Resuscitation and Management Bundle program was kicked off in 2012 as a hospital specific program. Applying process improvement methodologies to the Sepsis program will greatly enhance the chances of being success in implementing the plan and seeing reductions in mortality and average length of stay for improved health outcomes.

Related Category 3 Outcome Measure(s):

- IT-4.8 Sepsis mortality
- IT-4.9 Average length of stay

Applying process improvement methodologies to Sepsis programs will greatly enhance the chances of being successful in implementing the plan and seeing a reduction in mortality and average length of stay. We are implementing a standardized, evidence-based program for early detection and resuscitation of patients with severe sepsis and septic shock to reduce unnecessary death and harm attributable to sepsis: Institute for Healthcare Improvement; Surviving Sepsis Campaign; Society of Critical Care Medicine; IDSA Guidelines for appropriate antibiotic selection. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through multidisciplinary teams.

Relationship to other projects

This project supports the population focused improvements 094192402.4.4 RD-3 Potentially Preventable Complications (PPCs) and 094192402.4.6 RD- 5 Emergency Department. Improved quality with evidence based care for sepsis increases education, training, and screening that will reduce preventable complications in the hospital setting and ED care and treatment decisions.

Related Category 4 Population-focused improvements

- RD-3: Potentially Preventable Complications
- RD-5: Emergency Department

Relationship to other Performing Providers and Plan for Learning Collaboratives

The following providers are also proposing projects to address Sepsis Resuscitation and Management improvement:

Denton Regional Medical Center:	111905902.2.1
Medical City Dallas:	020943901.2.3
Medical Center of Lewisville:	094192402.2.3
Parkland Health & Hospital System:	127295703.2.6

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology:
Medical Center of Lewisville Center defined the population that will be directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The population expected to be positively impacted by the project for mortality was 647 which was determined based on outcome target for reduction in mortality by 20% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 17 . The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $198,129 for 5 years.
The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay by 20% from baseline average of 7 days per patient. This was estimated at total of reduced in patient days by DY 5 of 647. The estimated cost per day for a sepsis patient is $930. This totaled approximately $751,905.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $177,100.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 4. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $601,524.

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of mortality reduction at $177,100.

To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $526,333.

The total value of the project then was estimated at $2,431,091. Approximately 79.1% of the total value was assigned to Category 2 project ($1,923,053) and the remaining 10.46% of value assigned to Category 3 outcome for Sepsis Mortality ($254,518) and 10.46% assigned to Category 3 outcome for reduced Average Length of Stay ($254,520).

Rationale/Justification: The outcome improvement targets are dependent on the target population served (sepsis patients have increased rates of mortality), size, and also current processes in place that already treat Sepsis.

Community benefits were calculated using the following factors: lost productivity (net of lost wages), worker presenteeism, lost in payroll taxes and lost sales tax. Individual benefits were calculated using the following factors: lost wages, caretaker expense and extension of life (if applicable).

The economic value of each targeted improvement outcome from evidence based studies was used a guide for the overall value of project. Additional value was considered for resource investments needed, timelines, and risk and project scope.

094192402.2.2	*2.8.11*	***NA***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE BASED INTERVENTION THAT WILL LEAD TO REDUCTION IN SEPSIS COMPLICATIONS***
Medical Center of Lewisville			*94192402*
Related Category 3 Outcome Measure(s):	*094192402.3.2* *094192402.3.3*	*3 IT-4.8* *3 IT-4.9*	*Sepsis Mortality* *Average Length of Stay*

Year 2 (10/1/2012 – 9/30/2013)	**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 to do appropriate planning for implementing major infrastructure development or program/process re-design Metric 1 [P-X.1]: Documentation of Sepsis Improvement Plan Baseline/Goal: Plan Data Source: Plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $119,571 **Milestone 2** [P-6.]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events Baseline/Goal: Implement events Data Source: Plan Milestone 2 Estimated Incentive Payment *(maximum amount):* $119,572 **Milestone 3** [P-X]: Participate in a learning collaborative	**Milestone 5** [P-6]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events (Documentation of all steps conducted in the PDSA) Baseline/Goal: Develop a sepsis improvement plan Data Source: Plan Milestone 5 Estimated Incentive Payment: $163,059 **Milestone 6** [I-13.1]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1]: Number or percent of all clinical cases that meet target/goal Goal: Improve compliance from 10%above baseline, 107 cases Data Source: EHR Milestone 6 Estimated Incentive Payment: $163,059	**Milestone 8** [I-13]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1] Number or percent of all clinical cases that meet target/goal Goal: Improve compliance from 15% above baseline, 128 cases Data Source: EHR Milestone 8 Estimated Incentive Payment: $261,650 **Milestone 9** [I-13]: Progress toward target/goal (Compliance with correct timely diagnosis of Sepsis) Metric 1 [I-13.1.2]:Number or percent of all clinical cases that meet target/goal Goal: Improve Sepsis Diagnosis Compliance by 45% from baseline,141 cases Data Source: EHR Milestone 9 Estimated Incentive	**Milestone 10** [I-13]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1]: Number or percent of all clinical cases that meet target/goal Goal : Improve compliance from 20% above baseline, 147 cases Data Source: EHR Milestone 10 Estimated Incentive Payment: $216,146 **Milestone 11** [I-13]: Progress toward target/goal (Compliance with correct timely diagnosis of Sepsis) Metric 1 [I-13.1.2]:Number or percent of all clinical cases that meet target/goal Goal : Improve Sepsis Diagnosis Compliance by 55% from baseline, 155 cases Data Source: EHR

094192402.2.2	*2.8.11*	***NA***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE BASED INTERVENTION THAT WILL LEAD TO REDUCTION IN SEPSIS COMPLICATIONS***
Medical Center of Lewisville			*94192402*
Related Category 3 Outcome Measure(s):	*094192402.3.2* *094192402.3.3*	*3 IT-4.8* *3 IT-4.9*	*Sepsis Mortality* *Average Length of Stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 1 [P-X.1]: Submit report for Sepsis Improvement Plan findings Baseline/Goal: Annual conference Data source: Conference meeting attendance and minutes Milestone 3 Estimated Incentive Payment *(maximum amount):* $119,571 **Milestone 4** [P-X]: Establish baseline, in order to measure improvement over self (for correct timely diagnosis of sepsis and bundle compliance) Metric 1 [P-X]: Conduct assessment of targeted population Baseline/Goal: Percent compliance with correct timely diagnosis of sepsis Data source: EHR Milestone 4 Estimated Incentive Payment *(maximum amount):* $119,572	**Milestone 7** [I-13]: Progress toward target/goal (Compliance with correct timely diagnosis of Sepsis) Metric 1 [I-13.1.2]: Number or percent of all clinical cases that meet target/goal Goal: Improve Sepsis Diagnosis Compliance by 30% from baseline, 123 cases Data Source: EHR Milestone 7 Estimated Incentive Payment: $163,059	Payment: $261,649	Milestone 11 Estimated Incentive Payment: $216,145
Year 2 Estimated Milestone Bundle Amount: $478,286	Year 3 Estimated Milestone Bundle Amount: $489,177	Year 4 Estimated Milestone Bundle Amount: $523,299	Year 5 Estimated Milestone Bundle Amount: $432,291
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,923,053			

Project Option 2.9.1- Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Establish a Patient Care Navigation Program for ED Patients)

Unique Project ID: 094192402.2.3
Performing Provide Name/TPI: Medical Center of Lewisville/ 94192402

Provider: Medical Center of Lewisville is a 166-bed acute care hospital in Denton County, Texas serving a primary and secondary service population of approximately 340,000.

Intervention(s): This project will implement a Patient Navigation program to assist patients with health literacy and education, psychosocial support, and self-management education and support. The program will assist patient in obtaining primary care and other services for their medical care.

Need for the project: Currently over 50% of patients seen in the ED are Medicaid eligible or uninsured. Due to lack of resources, cultural barriers and fragmented system, medical care is utilized in ED in an episodic manner. The program will provide, case management, health literacy and education, psychosocial support, and self-management education and support assist patient in obtaining appropriate care in the right setting.

Target population: The target population is patients presenting to ED who are Medicaid eligible or uninsured who do not have access to appropriate medical care services. Approximately 53% of patients in the ED are Medicaid and indigent. There are an estimated 2000 patients who visit the ED more than 3 times year and 1300 patients who visit ED more than 4 times a year. Patients with visits > 4 times a year had an average of 5.77 visits per year. 47% of the patients with visits > 4 times in year were Medicaid eligible or indigent. The target population are those patients utilizing ED >4 times a year particularly those with visits >10 visits and those with chronic diseases. These are the goals for the number of patients the patient navigation program will serve- DY2-195, DY3- 325, DY4- 585 and DY5- 845 for a total of 1,950 patients.

Category 1 or 2 expected patient benefits: The project seeks to provide navigation services to patient who frequent the Emergency room services .Patient will be given access to support services such as ,assistance with transporation, language assistance, medication management and disease and health education. Interventions will be designed to assist patients to be compliant and successful in manageing their health. Patients with visits > 4 times a year had an average of 5.77 visits per year.The goal of navigation program will be the reduce the visit to average of 2 per year. It is reasonable to expect some ED visits from the target population due to chronic diseases, but a reduction is possible with primary care referrals and navigation interventions.
Category 3 outcomes: IT-4.8 Our goal is to reduce their inappropriate ED visits of the target population enrolled in navigation by 65 % by DY5 It is estimated the ED visits by target population if continued at 5.77 per year are DY3-1,875 DY4-3,375 DY5-4,876. With an effective

patient navigation program we anticpate the ED visits from patients in the patient navigation program will be reduced to DY3, -650, DY4-1,170 DY5-1,690, a reduction of 6,616 visits. The overall ED visits baseline is 43,000 visits per year, a reduction of 6,616 is an overall reduction in ED visits of 15% by DY 5,(DY3-3%, DY4 -5%, DY5-7%).

Project Description

As many providers in Dallas Fort Worth, Medical Center of Lewisville sees high utilize patients in the ED and acute care services many with chronic diseases that resources or knowledge of healthcare systems and often with mental and behavioral health issues. Medical Center of Lewisville will implement patient care navigation as it has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions The program will includes patient assessment, case management, health literacy and education, psychosocial support, and self-management education and support. With greater support and access to services, patients will utilize appropriate care services in the appropriate setting while reducing ED visits. With a reduction in inappropriate ED visits, hospitals will create capacity to better service those in need of true emergency services and allow for improved emergency care.

Goals and Relationship to Regional Goals

The goal of this project is to develop patient care navigation program to assist and coordinate with patients to find appropriate care and services needed. Patients find it difficult to obtain appropriate care which can be due to lack of health literacy, cultural barriers, lack of financial resources and fragmented systems. With assigning a health professional to a patient, achieving goals will be easier and more successful for patients in utilizing appropriate services and not rely on Emergency room for care. Because patients cannot access other services, they with often wait and at last minute with health issue exacerbated, go to ED when possible health outcome could have been avoided or lessened.

A major goal of the region is to pursue the triple aim of healthcare by improving patient experience of care, improve health of populations and reduce the cost of healthcare. Assisting patients to obtain health services in an appropriate setting will impact the health of our community by improving care received in a cost effective manner.

Challenges

Patient also routinely us ED as primary care but such expensive do not need such tertiary services as the ED is not meant to be a medical home. The best care is not delivered in this episodic manner. Our goal is to give patients the opportunity to access other services, reduce ED visits and better health outcomes for patients.

A major challenge will be the thoughtful and careful redesign of care delivery and communications processes resulting in a team approach to patient/family centered care, requiring a formally

structured, inclusive project management approach. This project will use proven process improvement methodologies to guide the redesign as well as use "lessons learned" from providers who have successfully redesigned care delivery in their practices. Additional challenges will include the acquisition of professional resources that have a background and training to provide social services and navigation care services, as well as overcoming the reliance on personal accountability of the patient to follow up with a provider in a more appropriate care setting.

5-Year Expected Outcome for Provider and Patients

At the end of the waiver, we expect to see utilization in ED decrease 65% for those patients use ED > 4 times a year as patients will access to appropriate in appropriate setting.

Starting Point/Baseline

Over use of the Emergency department services in the region rate of 447.5 visits per 1000 persons compared to national rate of 390.5 per 1000 persons in 2007. At Medical Center of Lewisville annually we see over 43,000 patients visits. In 2011, 1300 patients use the ED > 4 times in 12 month cycle and 2000 > 3 times. Although most patients presenting to ED need care, the appropriate setting for care needed /level of care may not be an Emergency room.

Emergency rooms become the safety net for individuals to seek healthcare with additional need including mental health services and social care needs. However emergency departments are not always equipped to properly coordinate with these patients seeking these services. Although many other organization exist in the community (churches, state and local agencies, and charitable organizations) finding these services can be difficult.

Navigation programs can screen patients and assess patients' risk of failure to meet healthcare goals. The program can develop an individual plan to best meet the needs of particular patient rather than a generalized discharge –for- all plans. Patients with individualized plans and support will have better results in achieving health outcomes and self- management goals.

Medical Center of Lewisville has seen increase in ED visits in to 43,000 a year, an annual increase of 13% in 2011. In 2011, 1300unique patients utilized the ED 4 times or greater with average visit count of 5.77 in the 12 month period and as many as 30 visits per patient There are an estimated 2000 patients who visit ED more than 3 times year and 1300 patients who visit ED more than 4 times a year. Patients with visits > 4 times a year had an average of 5.77 visits per year. 47% of the patients with visits > 4 times in year were Medicaid eligible or indigent. The target population are those patients utilizing ED >4 times a year particularly those with visits >10 visits and those with chronic diseases. These are the goals for the number of patients the patient navigation program will serve- DY2-195, DY3- 325, DY4- 585 and DY5- 845 for a total of 1,950 patients.

Rationale

Medical Center of Lewisville as seen an increase in ED visits in past 3 years average over 5% to 43,000 visits. Medical Center of Lewisville has initiatives in place in the ED to triage patients for urgent care and system wide ED throughput program. Although these initiatives continue to be successful, we continue to see increases in ED utilization particularly by frequent fliers. This project would an additive phase to the overall ED management initiative that would have 2 purposes. A navigation program serves patients by assisting them to obtain care in the appropriate setting and appropriate time in addition to better care for those patients truly in need of Emergency care services.

Project Components

This project will address the core components:
Identify frequent ED users and use navigators as part of a preventable ED reduction program.
Train health care navigators in cultural competency.
Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
Connect patients to primary and preventive care.
Increase access to care management and/or chronic care management, including education in chronic disease self-management.
Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

The milestones and metrics that we chose are directly related to two of the goals identified by the region: 1) need for more care coordination and 2) overuse of ED servicesThe metrics we have in place increase the number of the target population served over the Waiver period and emphasize the connection rate to a primary care for those without access. In addition, we have added a metric that creates regular reports that show comparative analyses year over year of the program. We believe by running detailed reports on what services were provided and how these coincide with the needs of the community, will allow for maximum effectiveness and positive outcomes of the project. These metrics directly impact the health and well-being of the patients served and ensures continuity in their care.

Unique Community Need Identification Numbers the Project Addresses

This project addresses the community need - CN.12 Emergency Department Usage and Readmissions.

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

We currently utilize Case Managers for ED patients however their roles as evolved to prioritize ED throughput and admissions. Case Managers do make referrals for care however they are not onsite 24/7 and do not have interaction with patients once they leave the ED. This initiative would add resources that can devote time to assisting patients with finding resources such as medical homes, support organizations and health education. The follow up with patients would be entirely new components to case managing in the ED.

Related Category 3 Outcome Measure(s):
IT-9.2 ED appropriate utilization (Standalone measure)

The outcome measure for IT-9.2 ED appropriate utilization (Standalone measure) was selected to reflect the impact of the navigation program and interventions on the on ED usage in the region as this a priority goal for the program. Patient navigators will provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services including assisting in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations.

Relationship to other projects
This project supports the focused improvement of 094192402.4.2 RD-1 Potentially Preventable Admission and 094192402.4.3 RD-2 30 day re-admission. By helping patients navigated the continuum of the health system and connecting them to primary and preventative care, patients will get care needed in the right setting. Patients will also benefit from the enhanced social support for their needs from culturally competent navigators. There is less risk of hospitalization if patients are able to access appropriate care and services.

Relationship to other Performing Providers and Plan for Learning Collaborative
The RHP 9 projects related to patient navigation include:

Performing Provider	Unique Project
Baylor Medical Center at Garland	121790303.2.3
Baylor Medical Center at Irving	121776204.2.3
Baylor University Medical Center	139485012.2.3
Children's Medical Center	138910807.2.3
Medical Center of Lewisville (HCA)	094192402.2.3
Methodist Charlton Medical Center	126679303.2.2
Methodist Dallas Medical Center	135032405.2.1
Methodist Richardson Medical Center	209345201.2.1
Parkland Health & Hospital System	127295703.2.7
Texas Health Presbyterian – Denton	020967801.2.1
Texas Health Presbyterian – Kaufman	094140302.2.1

University of Texas Southwestern – Faculty	126686802.2.4
University of Texas Southwestern – Hospital	175287501.2.1

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology:

Medical Center of Lewisville recognized that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, the project and outcomes was computed with a total value of the Category 3 outcomes connected to each project. Medical Center of Lewisville estimated the ED visits by target population if continued at 5.77 per year are DY3-1,875 DY4-3,375 DY5-4,876. With an effective patient navigation program we anticipate the ED visits from patients in the patient navigation program will be reduced to DY3, -650, DY4-1,170 DY5-1,690, a reduction of 6,616 visits. DY3, -650, DY4-1,170 DY5-1,690, a reduction of 6,616 visits. The average, direct cost of an ED visit from internal cost information is $250 per visit so for DY 3-5 cost saved would be $1,654,300. The patient navigation program, 4 year costs for the waiver period were estimated at $704,000. This cost included direct staff hired to run the navigation program (1-2 RN/case managers) and 10% overhead for management time and additional costs (transportation, interpreters, etc.). The total net value was $950,300 ($1,654,300 less $704,000). Approximately 79.06% of the total value was assigned to Category 2 project ($751,402) and the remaining 20.93% of value assigned to Category 3 outcome for reduction of ED visits ($198,898).

Rationale/Justification: The outcome improvement targets are dependent on the target population served size and also processes to be put in place to achieve the target. .

094192402.2.3	***2.9.1***	***2.9.1 (A-E)***	***ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM***	
		Medical Center of Lewisville		*94192402*
Related Category 3 Outcome Measure(s):	*094192402.3.4*	*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-2]: Establish/ expand 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: Hire appropriate staff- 1 -2FTEs Data Source: Documentation Metric 2 [P-2.2]: Number of unique patients enrolled in the patient navigation program; Baseline/Goal: Establish baseline of patients seen in DY2 Data Source: E.H.R./Navigation database Metric 3 [P-2.3]: Frequency of contact with care navigators for high risk patients.	**Milestone 3** [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. Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided Baseline/Goal: Provide completed report to compare types of navigation offered in DY2 v. DY3 Data Source: E.H.R/Navigation notes and database Milestone 3 Estimated Incentive Payment: $95,569 **Milestone 4** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric 1 [I-10.2]: Increased number	**Milestone 5** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric 1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care referrals to at least 40% of patients served by care navigation program Data Source: E.H.R./Patient Navigation program database Metric 2 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Serve at least 585patients Data Source: E.H.R./Patient Navigation program database Milestone 5 Estimated Incentive Payment: $204,470	**Milestone 6** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric 1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care referrals to at least 50% of patients served by care navigation program Data Source: E.H.R./Patient Navigation program database Metric 2 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Serve at least 845 patients Data Source: E.H.R./Patient Navigation program database Milestone 6 Estimated Incentive Payment: $168,911

094192402.2.3	*2.9.1*	*2.9.1 (A-E)*	*ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM*	
Medical Center of Lewisville				*94192402*
Related Category 3 Outcome Measure(s):	*094192402.3.4*	*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)
Baseline/Goal: Track frequency of patient contact w/navigator while in ED Data Source: E.H.R./Patient Navigation program database Milestone 1 Estimated Incentive Payment: $93,442 **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. Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided Baseline/Goal: Create report format and educate navigators about data points to be collected Data Source: Documentation of report Milestone 2 Estimated Incentive Payment: $93,441	of primary care referrals. Goal: Provide primary care referrals to at least 30% of patients served by care navigation program Data Source: E.H.R./Patient Navigation program database Metric 2 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Serve at least 325patients Data Source: E.H.R./Patient Navigation program database Milestone 4 Estimated Incentive Payment: $95,569		

094192402.2.3	***2.9.1***	***2.9.1 (A-E)***	***ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM***	
Medical Center of Lewisville				*94192402*
Related Category 3 Outcome Measure(s):	*094192402.3.4*	*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)**
Year 2 Estimated Milestone Bundle Amount: $186,883	Year 3 Estimated Milestone Bundle Amount: $191,138		Year 4 Estimated Milestone Bundle Amount: $204,470	Year 5 Estimated Milestone Bundle Amount: $168,911
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $751,402				

Project Option 2.15.1 – Integrate Primary and Behavioral Health care Services (Integrate Primary Care with Psychiatric Care Clinic)

Unique Project ID: 020943901.2.1
Performing Provider Name/TPI: Medical City Dallas/020943901

Provider: Medical City Dallas is a 586 -bed acute care hospital in Dallas, Texas serving a Primary and Secondary Service Area population of approximately 3.2 million.

Intervention(s): An integrated primary and behavioral health clinic will provide primary care for patients receiving OP psychiatric care at Green Oaks Hospital

Need for the project: Psychiatric disorders often have co-occurring medical issues and/or chronic disease. Community need assessment conducted for Region 9, noted the high rate of co-occurring mental and behavioral health in patients in ED. Despite the strong relationship between behavioral health and medical illness related outcomes and cost the percentage of the 200% FPL population receiving behavioral healthcare in primary care settings is below the national average in Dallas County (19.8% vs. 37.1%). Two thirds of the Indigent patients treated in NorthSTAR region are not eligible for Medicaid and lack access to primary care.

Target population: Our target population is will be those Medicaid and uninsured patients being treated for psychiatric care with known chronic diseases and medical health issues. Approximately 100% of patients are Medicaid eligible and indigent. It is estimated there are 10,000 psychiatric patients without access to primary care in the target population of psychiatric patients at Green Oaks Hospital. We estimate 50% have a chronic disease and 50% of chronic disease patients are not able to access primary care via hospital district (Parkland) or self insured funding.

Category 1 or 2 expected patient benefits: The project seeks to provide access to primary care for patients who currently do not have access and integrate psychiatric and medical care in a collaborative model. We estimated to have 50% of psychiatric patients with chronic disease without primary care access as patients in the new collaborative model (DY2-500, DY3-1,500, DY4-2,000 and DY5-2,500).

Category 3 outcomes: IT-2.4 Our goal is to reduce Behavioral Health/Substance Abuse (BH/SA) admission rate .5. We estimate admit rate for the target population to be 35%. Our goals is to reduce these admission by 10% per year from DY 2-DY5 for a total admission reduction of 230. We estimate the current region Behavioral Health/Substance Adbuse Admission rate to be .505%. We aim to reduce the rate by 1.3% by DY 5.
IT-3.8 Our goal is to reduce to reduce Behavioral Health/Substance Abuse (BH/SA) 30 day readmission rate by DY3-5%, DY4-5%and DY 5-10% for a total reduction of 20%. (DY3-40 DY4-40, DY5-81).

Project Description

This project will improve access to primary care through a collaborative integrated primary and behavioral health clinic. The integrated primary and behavioral health clinic will provide primary care for patients receiving OP psychiatric care at Green Oaks Hospital. Patients who are under the care of a psychiatrist at Green Oaks Hospital are evaluated for medication checks on an outpatient basis. The same clinic site will add an Internal Medicine physician to serve as a cohesive team to provide primary care services. Medical City Dallas will partner with Green Oaks Hospital to provide primary care at the clinic.

The team of psychiatrists and Internal medicine physicians will provide comprehensive care to NorthSTAR patients in the region. Many of these patients' are not able to access primary care as they do not have medical care coverage. Approximately two thirds of the patients seen at Medical City Dallas and Green Oaks from North STAR are indigent but do not qualify for Medicaid. This project will provide primary care to those who are not able to afford care in addition to integrating the patients' primary care with behavioral care. Patients who do have coverage for medical care through Medicaid or other insurance will also be eligible to use primary services at the clinic if they choose to do so.

In analyzing the prior 12 months of patients seen at Green Oaks, we have measured the prevalence of co-occurring health conditions with 10% of patients being diabetic, 20% having GI issues, and 14% with neurological issues. Cardiovascular disease was most prevalent with 40% of patients having cardiac problems. Medications for psychiatric care are known to exacerbate the problem as they are associated with obesity and high triglyceride levels, known risk factors for cardiovascular disease.
By addressing these health issues and chronic diseases, the clinic will be addressing the whole person to improve the continuity of care and result in better outcomes.

Our target population is will be those uninsured patients with known chronic diseases and medical health issues. The psychiatric and medical providers in the clinic will be on a common platform to share scheduling and medical records. Regular face- to-face communications will assist to facilitate a close collaboration among the providers Protocols, training and team building will be developed to ensure co-location is successful.

Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through the multidisciplinary teams.

Goals and Relationship to Regional Goals

The goal of this project: is to:

1. Provided primary care to patients under psychiatric care
2. Minimize the need for multiple sites and multiple providers for psychiatric patients for their care

3. Integrate the medical and psychiatric care for patients to achieve a collaborative model
4. Improve the health outcomes of psychiatric patients

This project addresses the regional goal to provide improved primary and behavioral health care to transform delivery of health care, improve patient health outcomes and reduce cost per capita. The purpose of this project is to reduce complications in psychiatric patients by addressing their chronic disease and health issues. With reduced complications we believe we have a greater chance to be successful in treating psychiatric disease. We believe with a focus in primary care there will reduce ED visits, admissions and re-admissions.

Challenge

Psychiatric patients often have medical issues that are not receiving treatment. There are various reasons for this lack of treatment including lack of medical coverage, lack of transportation, lack of support system, and inability to manage their care and lifestyle choices. In order to have the best chance of success in treating the whole person, integrating primary care with the psychiatric care will address both issues for continuity of a care and better health outcomes.

5-Year Expected Outcome for Provider and Patients

We expect to have 2500 unique patients by DY 5 andexpect to see over 16,250patient visits in integrated primary behavioral care clinic by the end of the waiver.

Starting Point/Baseline

The number of patients without access to primary care is not known. This will be measured as a baseline in DY 2. It is estimated that the number of patients being treated at Green Oaks in 2011 who do not have access to primary care is 10,000 and greater than 50% have a medical/chronic disease issue.

Rationale

Psychiatric disorders often have co-occurring medical issues and/or chronic disease. Community need assessment conducted for Region 9, noted the high rate of co-occurring mental and behavioral health in patients in ED. Despite the strong relationship between behavioral health and medical illness related outcomes and cost the percentage of the 200% FPL population receiving behavioral healthcare in primary care settings is below the national average in Dallas County (19.8% vs. 37.1%) The assessment also noted the mortality disparity of those patients with mental illness as the majority of premature deaths were attributed medical illnesses.

Nationally, patients with serious mental disorders often do not receive treatment for medical or physical issues. A review of 18 studies estimated that, on average, 35% of individuals with serious mental disorders have at least one undiagnosed medical disorder. Among people with

schizophrenia, fewer than 70% of those with co-occurring physical problems were currently receiving treatment for 10 of 12 physical health conditions studied.

Project Option

One way to improve primary care in these patients is to bring primary care services into psychiatric care settings.[315] Patients with schizophrenia may be a population that would benefit from integrated psychiatric and primary care because these patients generally use the mental health care as the main source of health care.[316] Patients with chronic psychiatric disorders other than schizophrenia also use the mental health care sector as a source of care, have co-occurring non psychiatric disorders, and could also benefit from integrated primary and psychiatric care.

Patients are more likely to make a primary care visit if it at same time and /or site of psychiatric care. By integrating primary and behavioral health care, patients will have their psychiatric and medical care addressed at the same site by providers who will coordinate their care. Placing primary care physicians in psychiatry settings improves health maintenance, care coordination, and satisfaction with medical care.

Providers will:

- Share medical records and knowledge of medical and psychiatric history and treatment
- Communicate face-to-face to on patient care
- Build a shared culture of treatment to include protocols and methods for information sharing
- Track treatment utilization and health outcome of integrated model

Project Components

All components of this project will be implemented to allow for a robust and successful project. They include:

a. Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community. Examples of selection criteria could include proximity/accessibility to target population, physical plant conducive to provider interaction; ability / willingness to integrate and share data electronically; receptivity to integrated team approach.

b. Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.

[315] Wulsin LR, Söllner W, Pincus HA. Models of integrated care. Med Clin North Am. 2006;90(4):647–677. [PubMed]
[316] Horvitz-Lennon M, Kilbourne AM, Pincus HA. From silos to bridges: meeting the general health care needs of adults with severe mental illnesses. Health Aff (Millwood) 2006;25(3):659–669. [PubMed]

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 Electronic health record system or participation in a health information exchange – depending on the size and scope of the local project.

g. Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.

h. Arrange for utilities and building services for these settings

i. Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.

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 "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

A plan for Integrating Primary Care with Psychiatric services will need to be developed. It will be necessary to establish the baseline of actual number of patients that do not have a primary care provider so we are able measure capacity needed and progress in improving the primary care access. The goals of the project extend beyond only providing primary care as integration is essential to success. Establishing protocols for referrals and the analyzing referrals will be necessary as guidelines for practitioners and measurement of the effectiveness of the co-

location. Of course co-location is only one part of the program with true integration as ultimate goal. To measure integration, standards will be used for to ensure effective information sharing and proper handling of referrals of psychiatric patients to primary care provider. Continuous quality improvement activities will be utilized ensure successful implementation.
The program will measure the number of patients receiving their primary care at the co-located site to ensure capacity is utilized and goal of program is met. The no show rate will also be monitored to know if patients are able to keep appointment and put in place interventions to increase rate of compliance with appointments and their psychiatric and medical care plan

Unique community need identification numbers the project addresses:

- CN.5 Behavioral Health
- CN.6 Behavioral Health and Primary Care
- CN.12 Emergency Department Usage and Readmissions

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

Green Oaks Hospital is an inpatient psychiatric acute provider in Dallas, Texas and part of the NorthSTAR provider network. The NorthSTAR Behavioral Health program has been jointly administered by the Texas Department of Mental Health and Mental Retardation (TDMHMR) and the Texas Commission on Alcohol and Drug Abuse (TCADA) as a 1915(b) Medicaid Waiver program in a seven-county area around Dallas. The program serves the medically indigent and most Medicaid recipients who reside within this region.

This is a new initiative for Medical City Dallas and Green Oaks Hospital. Green Oaks Hospital currently does not provide primary medical care for psychiatric patients. This project is not funded by NorthSTAR Value Options Behavioral Health program.

Related Category 3 Outcome Measures

- IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate
- IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate

Due to lack of access primary care, patients' medical issues often go untreated. By giving psychiatric patients access to primary care, patients can get appropriate treatment and level of care necessary for medical issues and reduce the risk of admission or readmission. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through multidisciplinary teams.

Relationship to other projects

This project supports the population focused improvements 020943901.4.2 RD-1 Potentially Preventable Admissions and 020943901.4.3 RD-2 Potentially Preventable 30-Day readmissions with evidence based care primary and behavioral care integration for psychiatric patients will reduce risk of patients needing hospitalization for acute medical needs.

Related Category 4 Population-focused improvements:

RD-1 PPA – 3. Behavioral Health and Substance Abuse
RD-2 PRR – 3. Behavioral Health and Substance Abuse
RD-5 Emergency Department

Relationship to other Performing Providers' Projects and Plan for Learning Collaboratives
The following providers are also proposing projects to address integrated primary and behavioral health services:

- Children's Medical Center: 138910807.1.4
- Denton County MHMR Center 135234606.2.2
- Dallas County MHMR dba Metrocare: 137252607.2.1

Learning Collaborative. We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology:
Medical City Dallas defined the population that will be directly impacted by the project as patients receive a primacy care medical home at the integrated primary care and behavioral care clinic.. The population expected to be positively impacted by the project for primary care and medical home is 2,500 patients by DY 5. The estimated pricing for medical home was $650 per year per patient. This value was obtained from averages of various PCMH studies (Intermountain Healthcare, Blue Cross Blue Shield, etc.) The value is based on investing in primary care patient centered medical homes resulting in improved quality of care and patient experiences and costs compared to non-PCMH patients and reductions in expensive hospital and emergency department utilization. This totaled approximately $4,225,000 for 5 years.
The population expected to be positively impacted by the project for reduction in Behavior Health/Substance Abuse admission rate and Behavior Health/Substance Abuse Readmission rate by DY 5. The estimated cost for a Behavior Health/Substance abuse admission from

internal data is $1878. A reduction of 230 admissions was valued at $431,940. A reduction of 161 readmissions was valued at $302,358. This totaled approximately $734,298.

The remainder of $53,125 for total value was reduced to balance total funding.
The total value of the project then was estimated at $4,906,173. Approximately 80.63% of the total value was assigned to Category 2 project ($3,901,150). The remaining 10.24% of value was assigned to Category 3 outcome for Behavior Health/Substance Abuse Admission Rate ($502,512) and 10.24% of value was assigned to Cat 3 outcome for Behavior/Substance Abuse Re-Admission-30day ($502,511).

Rationale/Justification:

The economic value of each targeted improvement outcome from evidence based studies was used a guide for the overall value of project. Additional value was considered for resource investments needed (Internal Medicine physician, clinic space, staff, IT, etc.), timelines, and risk and project scope.

020943901.2.1	*2.15.1*	***2.15.1.(A-J)***	***INTEGRATE PRIMARY CARE WITH PSYCHIATRIC CLINIC***	
		Medical City Dallas		*020943901*
Related Category 3 Outcome Measure(s):	*020943901.3.6* *020943901.3.7*	*3.IT-2.4* *3.IT-3.8*	*Behavioral Health/Substance Abuse (BH/SA) Admission Rate* *Behavioral Health/Substance Abuse (BH/SA)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 and submit a plan, in order to do appropriate planning for the implementation of adding primary care services to outpatient psychiatric clinic. Metric 1 [P-X.1]: Documentation of project for plan for adding primary care to psychiatric clinic Baseline/Goal: Plan Data Source: Integrated Primary and Psychiatric Care Plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $477,041 **Milestone 2** [P-X]: Establish baseline of patients who do not have primary care provider, in order to measure improvement for increase access to primary care Metric 1 [P-X]: Conduct assessment of targeted population Baseline: Percent of patients without a primary care provider Data source: Survey Milestone 2 Estimated Incentive Payment *(maximum amount):* $477,042	**Milestone 3** [P-6]: Develop integrated behavioral health and primary care services within co-located sites. Metric 1 [P-6.1]: Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system). Goal: 80% of providers achieve Level 4 Data Source: EHR, Milestone 3 Estimated Incentive Payment: $346,951 **Milestone 4** [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 providers and vice versa. Metric 1 [P-3.1]: Number and types of referrals that are made between providers at the location Baseline/Goal: Develop standards Data Source: Integrated Primary and Psychiatric Care Plan Metric 2 [P-3.3]: Number of referrals		**Milestone 6** [I-8]: Integrated Services Metric 1 [I-8.1]: % of Individuals receiving both physical and behavioral health care at established locations. Goal: Improve to 2,000 patients Data Source: EHR, claims data, registry Milestone 6 Estimated Incentive Payment: $521,939 **Milestone 7** [I-10]: No-Show Appointments Metric 1 [I-10.1]: % decrease the "no shows" for behavioral and physical health appointments Goal: Improve by 20% from baseline Data Source: EHR, scheduling systems Milestone 7 Estimated Incentive Payment: $521,940	**Milestone 8** [I-8]: Integrated Services Metric 1 [I-8.1]: % of Individuals receiving both physical and behavioral health care at established locations. Goal: Improve to 2,500 patients Data Source: EHR, claims data, registry Milestone 8 Estimated Incentive Payment: $431,167 **Milestone 9** [I-10]: No-Show Appointments Metric 1 [I-10.1]: % decrease the "no shows" for behavioral and physical health appointments Goal: Improve by 30% from baseline Data Source: EHR, scheduling systems Milestone 9 Estimated Incentive Payment: $431,168

020943901.2.1	*2.15.1*	***2.15.1.(A-J)***	***INTEGRATE PRIMARY CARE WITH PSYCHIATRIC CLINIC***	
	Medical City Dallas			*020943901*
Related Category 3 Outcome Measure(s):	*020943901.3.6* *020943901.3.7*	*3.IT-2.4* *3.IT-3.8*	*Behavioral Health/Substance Abuse (BH/SA) Admission Rate* *Behavioral Health/Substance Abuse (BH/SA)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)**
	which follow the established standards Goal: 1500 patients Data Source: EHR, registry Milestone 4 Estimated Incentive Payment: $346,951 **Milestone 5** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services. Metric 1 [P-6.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles. Goal: complete all steps in PDSA Data Source: Integrated Primary and Psychiatric Care Plan Milestone 5 Estimated Incentive Payment: $346,951			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $954,083	Year 3 Estimated Milestone Bundle Amount: $1,040,853		Year 4 Estimated Milestone Bundle Amount: $1,043,879	Year 5 Estimated Milestone Bundle Amount: $862,335
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,901,150				

Projection Option 2.8.11- Implement an Innovative and Evidence Based Intervention that will lead to reduction in Sepsis Complications (Apply Process Improvement Methodology to Improve Quality/Efficiency)

Unique Project ID: 020943901.2.3
Performing Provider Name/TPI: Medical City Dallas/020943901

Provider: Medical City Dallas is a 586 -bed acute care hospital in Dallas, Texas serving a Primary and Secondary Service Area population of approximately 3.2 million.

Intervention(s): This project will implement process improvement methodologies in a sepsis evidenced based care program to reduce sepsis complications. Interventions will include implementing houseiwde 12/hour screenings on all patients, ED protocols, ICU Sepsis evidence based care treatment protocols and developing a measurement and reporitng system.

Need for the project: The current diagnosis and treatment of sepsis is not adequate for patient safety and quality of care with mortality as high as 60 % . Complications from lack of timely and appropriate treatment of sepsis including lifetime health issues, disability and mortality puts an unnecessary burden on society and the healthcare system. Process improvement methodologies will facilitate analysis of the evidence based program and implementation of corrective actions to improve implementation and maximize outcomes.

Target population: . The target population for diagnosing sepsis arepatients presenting to ED and all patients in house. . By initiating housewide screening every 12 hours on patients , we believe the number of patients diagnosed will increase. Once diagnosed with sepsis hock, severe sepsis, evidence based treatment is necessary Approximately 32% of patients to be screened are Medicaid and indigent. It is estimated currently 18% of our patients screened and treated for sepsis are Medicaid eligible or indigent. Based on current processes over 740 patients will be treated over course of the waiver, however with improvement in diagnosis a key element of the program, this number is expected to increase to estimated 1393 patients over 5 years Patients who are Medicaid eligible or uninsured will benefit as they more often use the ED and their illness is farther progressed when presenting to ED along with greater complexity of co-morbid diseases. Due to lack of access to medical care patients tend to delay seeking care which can lead to harmful results. The quicker diagnosis of sepsis and evidence-based care will prevent greater mortality and disability from sepsis.

Category 1 or 2 expected patient benefits: The project seeks to increase the timeliness of correctly diagnosing sepsis in order the begin evidence based care with improved the compliance with Sepsis Bundle and Resuscitation for patients diagnosed with severe sepsis and septic shock. . We expect to diagnose and treat 1393 sepsis patients (estimated at DY 1- 148, DY2-222, DY 3- 278, DY 4-347, DY 5-400). 148 patients were diagnosed in DY 1 with the implementation of the sepsis program. However only 33 patients were properly treated with the evidence based care plan from the program. In addition it is estimated based on similar size hospitals with sepsis programs, we should expect to diagnosis 400 patients a year. Potentially

we are not properly diagnosing 300 patients a year. Patients that may not diagnosed/diagnosed timely or not receive evidence based treatment may have resulted in death or disability. The program will have great benefit to patients to reduce harm from lack of proper and timely diagnosis and/or lack of evidence based treatment.

Category 3 outcomes: IT-4.8 Our goal is to reduce the Sepsis Mortality of patients diagnosed with sepsis from 24% currently to 20% by DY5. The estimated DY 1 mortality was 24% and improvement of 20% by DY 5, morality would be 20%
IT -4.9 Our goal is the reduce the Average length of stay of patients with sepsis by 10% in DY 4 and 20 % in DY 5. Estimated DY 1 ALOS was 10.0 , a reduction goal by DY 5 of 2 days to ALOS of 8.0.

Project Description

The project will design and implement a Process Improvement plan to increase the utilization and compliance with Sepsis Resuscitation and Management Bundles to improve patient outcomes.

Medical City Dallas is committed to continuous quality improvement so all of our patients receive the safest and highest quality health care possible. We are implementing a standardized, evidence-based program for early detection and resuscitation of patients with severe sepsis and septic shock to reduce unnecessary death and harm attributable to sepsis. Our processes and interventions are based upon evidence-based care models, which include a sepsis resuscitation bundle for Emergency Department (ED) patients and a sepsis management bundle for ongoing care. Rapid diagnosis and management are cornerstones to successful outcomes.

The ICU and ED plans for improvements in sepsis identification and treatment includes, revising the electronic nurse sepsis screening at triage, implementing an electronic nurse sepsis screen to aid in early detection of inpatients, staff education regarding sepsis screening, and refining the Rapid Response Team (RRT) processes to include sepsis screening and initial resuscitation. This allows the RRT to begin fluid resuscitation on the in-house patient that screens positive for severe sepsis or septic shock and is hypotensive.

Medical City Dallas will also track primary endpoints of mortality and ICU LOS. Process and other measures will be tracked that include, percentage of patients initiated on vasopressors and mean days of vasopressor use, percentage of patients initiated on the mechanical ventilator and mean ventilator days, and initiation of hemodialysis or continuous renal replacement therapy.

Our target population is any patient diagnosis of severe sepsis, septic shock, and/or lactate >4mmol/L (36mg/dl).

Although great work has been done to implement protocols and interventions, utilization and compliance of Sepsis Resuscitations and Management Bundles are still remains a challenge. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through multidisciplinary teams.

Goals and Relationship to Regional Goals

The goal of this project is to implement Process Improvement plan to improve safety and quality for those patients with Sepsis. We will:

1. Achieve 90%Compliance with the Sepsis Resuscitation and Management Bundles in patients admitted to the ICU.
2. Substantially improve early sepsis identification, reduce sepsis related Mortality by 20% from baseline
3. Effective and fully implemented measurement and reporting system supporting compliance with the Sepsis Resuscitation and Management Bundles.
4. Continue to work with Emergency Medical Services to improve the delivery of care provided to patients with suspected infection
5. Improve identification of sepsis patients' house wide by implementing nursing admission screening and shift assessments for sepsis screening
6. Improve identification of sepsis, compliance from TBD with current Sepsis Resuscitation and Management Bundles in the Emergency Department.

This project supports the regional goals to improve the patient care experience, health outcomes for the population and the per capita cost of care. Specifically, this project will improve the early diagnosis of patients with severe sepsis and septic shock so that evidence based care can be delivered. Improved recovery of patients with severe sepsis and septic shock will reduce unnecessary death and harm and reduce cost of post hospital care in addition to quality-adjusted life gained

Challenges

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. The eighth leading cause of death is influenza and pneumonia combined, and pneumonia is a leading source of severe sepsis and septic shock. Septicemia, influenza, and pneumonia deaths in 2007 contributed to over 80,000 deaths. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. In the United States, there are approximately 750,000 new cases of sepsis, which includes diagnoses of severe sepsis and septic shock, each year, and mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Proactive analysis of the contributing factors contributing to the design of evidenced based standardized care sets and subsequent adoption of those tools will contribute greatly to reducing variation and associated cost. Early recognition and management of sepsis results in lives saved.

5-Year Expected Outcome for Provider and Patients

We expect to each 100% compliance in identification/diagnosing of patients with severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl). We also expect to be 90% compliance with application of the Sepsis Bundles for patients that meet specified criteria.

Starting Point/Baseline

. The number of patients with severe sepsis, septic shock and/or lactate>4mmol/L (36mg/dl) that would qualify for sepsis resuscitation and management bundles based on expected sepsis claims from similar size hospital and mature sepsis programs would be 400 per year for a total of 1393 patient over course of the waiver. The hospital only diagnosed 148 patients in DY 1. Of those patients diagnosed only 33 received evidenced based care for sepsis bundles. Active implementation of sepsis resuscitation and management bundles and data collection is beginning in 2012. Early data collection indicates compliance with sepsis bundles is a low as 3%. It is expected that the morality rate for this population in DY 2 will initially increase compared to DY 1 due to more patients being correctly diagnosed with new sepsis protocols thus a baseline will be established in DY2 to measure same mortality based on same standards of care. The same is true for average length of stay, although it may decrease rather tha increase. A baseline in DY 2 is necessary to measure patients receiving the same protocol based diagnosis and standard of care.

Rationale

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. The eighth leading cause of death is influenza and pneumonia combined, and pneumonia is a leading source of severe sepsis and septic shock. Septicemia, influenza, and pneumonia deaths in 2007 contributed to over 80,000 deaths. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. In the United States, there are approximately 750,000 new cases of sepsis, which includes diagnoses of severe sepsis and septic shock, each year, and mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Our internal data shows a mortality rate as high as 60%. Identification and treatment protocols have been developed and implemented to impact mortality and ICU LOS which has improved. Although program components have been implemented and put in place, we still face the challenge of successful implementation. Also, additional interventions will be implemented in the future (shift assessments on all in-house patients etc). To be successful we need to work on processes that create time delays, non-adherence to order set and, failure to identify/diagnose

sepsis. We are at 22% compliance in implementing Sepsis Bundles. We believe in order to continue to see improvement from initial implementation, continuous quality improvement through data collection, analysis and review will accelerate change through our multidisciplinary teams.

Project Components

The project components to report metrics for Sepsis Mortality and Average Length of Stay are necessary to measure the success of implementing the Sepsis Improvement Plan.

A Sepsis Improvement Plan must have key elements to be successful. A project plan is necessary to identify and engage all stakeholders (ED, Inpatient Units, and EMS etc.), understand current status, resources, baselines, roles and responsibilities, expectations of individuals and outcomes. In order to have an impact on reduction in mortality and average length of stay compliance with Sepsis diagnosis and protocols for Sepsis Bundles are critical. In implementation of a plan, it is necessary to examine the plan as it is implemented, understand what is working and what is not, identify barriers and make corrective action. Continuous quality improvement (CQI) activities will be conducted to ensure successful implementation. In DY2 and DY 3, milestones to implement a program to improve efficiencies and/or reduce program variation are essential to the success of sepsis program. The practice strategy for PDSA and CQI will be a Lean Six Sigma DMAIC approach. A Value Stream Mapping will allow us to document the current state of the program implemented in 2012. The Value Stream Mapping and metric results will determine where variation exits and which processes are constraints to the success of the program. This will help us identify the priority for processes improvement events to be conducted. The team will conduct events utilizing tools to find root causes of variations or process delays. Changes will be implemented with appropriate tools to update the program process. To sustain results of changes implemented, audits at 6 months and 12 months will be utilized for each process improvement event. Each year a Value Stream Mapping can be utilized to validate change, document current state and continue the cycle of process improvement.

Unique Community Need Identification Numbers the Project Addresses

CN.11 Patient Safety and Quality

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

Sepsis Resuscitation and Management Bundle program was kicked off in 2012 as a hospital specific program. Applying process improvement methodologies to the Sepsis program will greatly enhance the chances of being success in implementing the plan and seeing reduction in mortality and average length of stay.

Related Category 3 Outcome Measures

Applying process improvement methodologies to Sepsis programs will greatly enhance the chances of being success in implementing the plan and seeing reduction in mortality and average length of stay.

IT-4.8 Sepsis mortality
IT-4.9 Average length of stay

We are implementing a standardized, evidence-based program for early detection and resuscitation of patients with severe sepsis and septic shock to reduce unnecessary death and harm attributable to sepsis: Institute for Healthcare Improvement; Surviving Sepsis Campaign; Society of Critical Care Medicine; IDSA Guidelines for appropriate antibiotic selection. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through multidisciplinary teams.

Relationship to other projects

This project supports the population focused improvements 020943901.4.4 RD-3 Potentially Preventable Complications (PPCs) and 020943901.4.6 RD- 5 Emergency Department. Improved quality with evidence based care for sepsis increases education, training, and screening that will reduce preventable complications in the hospital setting and ED care and treatment decisions.

Related Category 4 Population-focused improvements

This project supports the population focused improvements 094192402.4.4 RD-3 Potentially Preventable Complications (PPCs) and 094192402.4.6 RD- 5 Emergency Department. Improved quality with evidence based care for sepsis increases education, training, and screening that will reduce preventable complications in the hospital setting and ED care and treatment decisions.

Relationship to other Performing Providers and Plan for Learning Collaboratives

The following providers are also proposing projects to address Sepsis Resuscitation and Management improvement:

Denton Regional Medical Center (HCA): 111905902.2.1
Medical Center of Lewisville (HCA): 094192402.2.3

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology:

Medical City Dallas defined the population that will be directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The population expected to be positively impacted by the project for mortality was 1,393 which was determined based on outcome target for reduction in mortality by 20% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 50. The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $740,000 for 5 years.

The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay of 2 days from baseline average of 10 days per patient. This was estimated at total of reduced in patient days by DY 5 of 888. The estimated cost per day for a sepsis patient is $1,055. This totaled approximately $1,171,050 ($234,040 average per year).

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $740,000.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 3. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $702,630.

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.

This value was estimated as a proportion of mortality reduction at $716,847.

To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.

This value was estimated as a proportion of length of stay reduction at $585,525.

The total value of the project then was estimated at $4,656,052. Approximately 80.64% of the total value was assigned to Category 2 project ($3,753,964)and the remaining 9.68% of value assigned to Category 3 outcome for Sepsis Mortality ($451,044) and 9.68% assigned to Category 3 outcome for reduced Average Length of Stay ($451,044).

Rationale/Justification: The outcome improvement targets are dependent on the target population served (sepsis patients have increased rates of mortality), size, and also current processes in place that already treat Sepsis.

Community benefits were calculated using the following factors: lost productivity (net of lost wages), worker presenteeism, lost in payroll taxes and lost sales tax. Individual benefits were calculated using the following factors: lost wages, caretaker expense and extension of life (if applicable).

The economic value of each targeted improvement outcome from evidence based studies was used a guide for the overall value of project. Additional value was considered for resource investments needed, timelines, and risk and project scope.

020943901.2.3	*2.8.11*	***N/A***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE BASED INTERVENTION THAT WILL LEAD TO REDUCTION IN SEPSIS COMPLICATIONS***
Medical City Dallas			*20943901*
Related Category 3 Outcome Measure(s):	*020943901.3.9* *020943901.3.10*	*3 IT-4.8* *3 IT-4.9*	*Sepsis Mortality* *Average Length of Stay*

Year 2 (10/1/2012 – 9/30/2013)	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, do appropriate planning to implement major infrastructure development or program/process redesign Metric 1 [P-X.1]: Documentation of Sepsis Improvement Plan Baseline/Goal: Plan Data Source: Plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $229,521 **Milestone 2** [P-6.]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events Baseline/Goal: Implement events Data Source: Plan Milestone 2 Estimated Incentive Payment *(maximum amount):* $229,521 **Milestone 3** [P-X]: Participate in a learning collaborative Metric 1 [P-X.1]: Submit report for	**Milestone 5** [I-13.1]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1]: Improve implementation of Sepsis Bundle Compliance Goal: Improve compliance to 50% of patients diagnosed,139 patients on bundle Data Source: EHR Milestone 5 Estimated Incentive Payment: $500,791 **Milestone 6** [P-6]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events (Documentation of all steps conducted in the PDSA) Baseline/Goal: Develop a sepsis improvement plan Data Source: Plan Milestone 6 Estimated Incentive Payment: $500,792	**Milestone 7** [I-13]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1]: Improve implementation of Sepsis Bundle Compliance Goal: Improve compliance to70% of patients diagnosed , 243 patients on bundle Data Source: EHR Milestone 7 Estimated Incentive Payment: $502,247 **Milestone 8** [I-13]: Progress toward target/goal (correct diagnosis of Sepsis) Metric 1 [I-13.1.2]: Goal: Improve Sepsis Diagnosis 347 patient Data Source: EHR Milestone 8 Estimated Incentive Payment: $502,248	**Milestone 9** [I-13]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1]: Improve implementation of Sepsis Bundle Compliance Goal : Improve compliance to 90% of patients diagnosed, 359 patients on bundleData Source: EHR Milestone 9 Estimated Incentive Payment: $414,900 **Milestone 10** [I-13]: Progress toward target/goal (correct diagnosis of Sepsis) Metric 1 [I-13.1.2]: Goal : Improve Sepsis Diagnosis 400 patients Data Source: EHR Milestone 10 Estimated Incentive Payment: $414,900

020943901.2.3	*2.8.11*	***N/A***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE BASED INTERVENTION THAT WILL LEAD TO REDUCTION IN SEPSIS COMPLICATIONS***
Medical City Dallas			*20943901*
Related Category 3 Outcome Measure(s):	*020943901.3.9* *020943901.3.10*	*3 IT-4.8* *3 IT-4.9*	*Sepsis Mortality* *Average Length of Stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Sepsis Improvement Plan findings Baseline/Goal: Annual conference Data source: Meeting minutes Milestone 3 Estimated Incentive Payment *(maximum amount):* $229,522 **Milestone 4[P-X]:** Establish baseline, in order to measure improvement over self (for correct diagnosis of sepsis and bundle compliance) <u>Metric 1</u> [P-X]: Establish baseline for correct diagnosis of sepsis Baseline/Goal: Percent with correct diagnosis of sepsis Data source: EHR <u>Metric 2</u> [P-X]: Establish baseline for bundle compliance Baseline: 2011 Sepsis Bundle compliance estimated 22% Data source :EHR Milestone 4 Estimated Incentive Payment *(max amount):* $229,522			
Year 2 Estimated Milestone Bundle Amount: $918,086	Year 3 Estimated Milestone Bundle Amount: $1,001,583	Year 4 Estimated Milestone Bundle Amount: $1,004,495	Year 5 Estimated Milestone Bundle Amount: $829,800
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,753,964			

Project Option 2.1.1- Enhance/Expand Medical Homes at Metrocrest Clinic

Unique Project ID: 020943901.2.4 (Pass 2)
Performing Provider Name/TPI: Medical City Dallas/020943901

Provider: Medical City Dallas is a 586 -bed acute care hospital in Dallas, Texas serving a Primary and Secondary Service Area population of approximately 3.2 million.

Intervention(s): This project will enhance the operations of the Metrocrest Medical Clinic to be a medical home provider for indigent patients.

Need for the project: The clinic has operated as a primarily volunteer staffed clinic with limited full time personnel and stable medical services. By enhancing the clinic with stable provider hours and services, we will expand and enhance the clinic operations to provide a medical home services to patients.

Target population: The target population is patients seeking medical care at Metrocrest Clinic. Approximately 100% of the patients seen are either Medicaid eligible or indigent.

Category 1 or 2 expected patient benefits: The project will improve the number of patients assigned to a medical home to 80%. It is expected that total patients will increase from 1500 to 2600 over the course of the waiver (DY1-1500, DY2-1725, DY3-1980, DY4-2280, DY5-2600). We expect by the end of the waiver 96% of new patients will be assigned a medical home (new patients/patient in medical home=DY2 225/180, DY3-259/228, DY4—298/274, DY5-342/329 for a total new patients of 1,124 and 1,010 assigned to medical home). It is also estimated of the 1500 existing patients ,70% will be assigned to medical home and so by DY 5 total medical home patients 80 % of patient served by clinic (2600 total patients, 2080 assigned to medical home).

Category 3 outcomes: IT-11.5 Our goal is to reduce the All-cause Admission Rate for Chronically-ill patients in medical home by 10% in DY4 and 15% by DY5.

Project Description:
Dallas County's public hospital is at, or has exceeded, its currently available primary care capacity. Community hospitals and private physicians are limited in their ability to meet the need, based on current reimbursement/financing mechanisms. This project builds upon existing resources/relationships and focuses on transforming a community/charity clinic to a patient centered medical homes. The PCMH provides a primary care "home" for the patients. Patients are assigned to a "home" with a health care team who provides services based on a patient's unique health needs, effectively coordinates the patient's care across inpatient and outpatient settings and proactively provides preventive, primary, routine and chronic care.

Medical City Dallas has partnered with the Metrocrest Family Medical Clinic, a community clinic in Farmers Branch, Texas to provide a primary care to uninsured patients. Metrocrest Family Medical Clinic will see 4,000 to 5,000 visits in 2012. It has grown steadily in the past 2 years with the addition of a Medical City Internal Medicine physician who is available full time at the clinic. However the clinic has also relied heavily on volunteer staff and providers.

The clinic will seek Patient Centered Medical Home designation with the assistance of Medical City Dallas Hospital.

Clinics and Primary Care Physicians

Clinics and primary care physicians serve as the medical home for patients. The principle role is to provide a single point of accessible, continuous, comprehensive and coordinated medical care which includes specialists, hospital and post-acute care.

Community Care Transitions

Staff performing community care transitions will be supported by a CHW or social worker from Medical City Dallas. Their principle role is to respond to patient referrals to facilitate efficient hospital discharge and post-acute care connection to a primary care clinic or physician.

Community Pharmacy Navigation

Staff performing pharmaceutical navigation are dedicated to facilitating the continuous access to prescribed medications for low-income, uninsured chronically ill patients. The principle role is to assist patients taking chronic disease management medications to access affordable generic and brand named products from pharmaceutical company patient assistance programs.

Community Case Management

Staff performing case management are qualified personnel dedicated to helping the primary care clinic and physician provide chronic disease management to complex patients. It is estimated that 5-10% of the population will require Case Management services. This service enables clinic to accept the sickest, most challenging patients from community.

Goals and Relationship to Regional Goals:

The purpose is to expand and improve a community-based, multi-stakeholder, health care access program increasing the capacity to care for more uninsured Region 9 residents while demonstrating accountability for improved health outcomes.
Key functional elements include:

- Assess current clinic operations and perform gap analysis for achieving certified patient centered medical homes status.
- Implement strategic plan to address gaps and begin pathway to achieving certified medical home status
- Partnering with community hospital committed to efficient post-acute care transitions.

- Community Care Transitions staff facilitating effective and efficient post-acute care
- Case Management staff facilitating chronic disease care plans
- A Quality Improvement Plan to help achieve improved outcomes.

How this project addresses regional goals

A major goal of the region is to provide improved access to coordinated primary care. This project would contribute to achieving that goal by implementing a collaborative across multiple providers at clinic and hospital committed to identifying eligible uninsured residents access to a patient centered medical home. The project is supportive of improving regional access to care for eligible low income Region 9 residents and improving health outcomes.

Challenges

Community hospitals and private physicians are limited in their ability to meet the needs of the growing number of the uninsured population. This project aims to expand access to this population by creating a patient centered medical home which will increase efficiency and reduce the cost of providing care to this population. Options for the uninsured to access coordinated and comprehensive health care are limited. This project was specifically selected because the Medical City Dallas has a history of working together with Metrocrest Clinic to address these needs of eligible uninsured residents in Region 9. The project aims to provide patients with additional high quality services that are accountable and measurable and improve their care and health care experience.

5 Year Expected Outcomes

The expected outcomes for Metrocrest Family Medical Clinic are to provide the following for a "cohort" of uninsured/underinsured Region 9 residents:

Core Outcomes

- Establish medical home assignment criteria
- Identify evidence based training materials for medical homes based on model change concepts
- Identify and increase in the number of patients obtaining primary care medical home
- Identify and improve the number/percent of new patients that receive their first appointment in a timely manner

Starting Baseline:

The clinic had approximately 1500 unduplicated patients at the clinic in 2011. It is estimated that a significant percentage of these patients will qualify for medical home assignment. However the criteria will need to be developed and a baseline established in DY 2. Based on

that experience, we plan to increase the number of eligible patients assigned to a medical home to 80% of eligible patients at the clinic. Medical City Dallas has partnered with the Metrocrest Family Medical Clinic since 2010 to provide a primary care to patients. In 2012, Metrocrest will see 4,000 medical visits.

Rationale:

As indicated in the Dallas Fort Worth Hospital Council's RHP 9 Community Needs Assessment, there is a strong demand for primary care services. The demand for hospital, primary care and specialty care services exceeds the supply of available medical physicians in the hospital's service area, thus limiting health care access for many low level management or specialized treatment for prevalent health conditions. Many primary care physicians accept a limited number of the Medicaid/Uninsured population due to the lack of coordination of care and access to appropriate ancillary services. Consequently, many residents seek primary care treatment in emergency care settings resulting in increased healthcare costs and higher volumes of preventable and avoidable cases populating emergency department waiting rooms. Thus, improved/continued support to physicians, community/charity clinics and hospitals the implementation of innovative approaches can have a significant impact on the uninsured ability to access care and improve outcomes. We have selected this project to enhance the role of the of community/charity clinics by creating more patient centered medical care home options in the region. The key project components will be addressed

Project Components

Our project includes the following components to develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards. Required core project components of option 2.1.1:

- Utilize a gap analysis to assess community/charity clinics' NCQA PCMH readiness.
- Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status
- Conduct educational sessions for community/charity clinic's boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision.
- 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.

Our milestones measure an increased population receiving care through a PCMH model of care: (1) we are establishing and implementing medical home assignment criteria, (2) we are utilizing evidence based training materials for medical homes based upon model change concepts, (3) we are increasing the number of eligible patients assigned to a medical home, (4) we are increasing the number of new patients assigned to medical homes that are contacted for medical visit within 60 – 120 days and (5) we are documenting medical home recognition/accreditation of community/charity clinic by a nationally recognized agency

Unique Community Need Identification Numbers the Project Addresses:

CN.3 Healthcare Capacity
CN.8 Chronic Disease

How the project significantly enhances an existing delivery system reform initiative

This project enhances an existing partnership of Medical City Dallas Hospital and Metrocrest Family Clinic. This project expands/increases the number of patients accessing care at a medical home and establishes a quality improvement committee to look at clinical outcomes.

Related Category 3 Outcome Measures:
Outcome measure and Reason/rationale for selecting the outcome measures:
The impact can be measured by one standalone Category 3 Outcome Measure IT-11-5 All-Cause Admission Rate for Chronically-Ill patients. This measure is will demonstrate the importance of assigning low income uninsured residents to a medical home. As indicated in the Dallas Fort Worth Hospital Council's RHP 9 Community Needs Assessment, an analysis of the emergency department encounters demonstrates that many in the population are accessing emergency departments for both urgent and non-urgent conditions. Emergency room encounters that result in an in-patient admission tend to be more complex in nature and based on the data, the most frequent conditions that lead to admissions were: stroke, congestive heart failure, weak/failing kidneys, heart attack, and chronic bronchitis. There is a correlation between hospitalization for chronically-ill patients and access to primary care. Timely and effective primary care could reduce the risk of hospitalizations due to ambulatory care sensitive conditions.

Relationship to other Projects:
This project is related to 020943901.4.2, 209439013.4.5 and 20943901.4.6. The program will work with patients to find available primary care/ medical home and other health care services in the community rather than utilize emergency department costly care.

Relationship to other Performing Providers in the RHP and Plan for Learning Collaboratives:
The following providers are also proposing projects to address expanding medical homes:

- Baylor University Medical Center
- Baylor Garland
- Baylor Irving
- Methodist Dallas Medical Center
- Texas Health Presbyterian Health Dallas

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that

is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation:

Approach/Methodology: Medical City Dallas defined the population that will be directly impacted by the project as patients assigned a medical home at the Metrocrest clinic. There were 2 measures used for this project valuation, patient provided a medical home and reduced admissions. The population expected to be positively impacted by the project for primary care and medical home is 2080 patients by DY 5. Full value was given to new patients estimated assigned to medical home (DY2-180, DY3-228, DY4-274, DY5-329) but only 70% of value was given to patients already clients of clinic (1050). The estimated pricing for medical home was $650 per year per patient. This value was obtained from averages of various PCMH studies (Intermountain Healthcare, Blue Cross Blue Shield, etc.) The value is based on investing in primary care patient centered medical homes resulting in improved quality of care and patient experiences and costs compared to non-PCMH patients and reductions in expensive hospital and emergency department utilization. This totaled approximately $ 3,392,430 for 4 years.

The population expected to be positively impacted by the project for reduction in All –cause admissions 70 admissions by DY 5. The estimated cost for admissions from internal data is $7,100. This totaled approximately $497,000.

The remainder of $66,847 for total value was reduced to balance total funding.

The total value of the project then was estimated at $3,822,583. Approximately 78.68% of the total value was assigned to Category 2 project ($3,007,899)and the remaining 21.31%% of value assigned to Category 3 outcome for All Cause Admission ($814,684).

- **Rationale/Justification:** The outcome improvement targets are dependent on the target population served (chronic illness patient tions will have increased admissions due to higher incidence rates), size and also current processes in place that already prevent avoidable hospitalizations.

020943901.2.4	***2.1.1***	***2.1.1 (A-D)***	***ESTABLISH A MEDICAL HOME AT METROCREST CLINIC***	
	Medical City Dallas			*020943901*
Related Category 3 Outcome Measure(s):	*020943901.3.11*	*3 IT-11.5*	*All-cause Admission Rate for Chronically-ill patients in medical home*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-6]: Establish/ implement criteria for medical home assignment Metric 1 [P-6.1]: Medical home assignment criteria Goal: develop and adopt Data source: Submission of medical home assignment criteria Milestone 1 Estimated Incentive Payment: $188,064 **Milestone 2** [P-8]: Develop or utilize evidence based training material for medical homes based upon model change concepts Metric 1 [P-8.1]: Documentation of training materials Goal:100% complete Data Source: Training materials Milestone 2 Estimated Incentive Payment: $188,063 **Milestone 3** [I-12]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes.	**Milestone 5** [P-8]: Develop or utilize evidence based training material for medical homes based upon model change concepts Metric 1 [P-8.1]: Documentation of training materials Goal: 100% staff/providers trained Data Source: HR records, training materials Milestone 5 Estimated Incentive Payment: $256,270 **Milestone 6** [I-12]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric 1 [I-12.1]: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the performing provider. Goal: 5% improvement over baseline Data Source: EHR, Patient database Milestone 6 Estimated Incentive Payment: $256,270 **Milestone 7** [I-13]: New patients assigned to a medical home receive		**Milestone 8** [I-12]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric 1[I-12.1]: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the performing provider. Goal: 10% improvement over baseline Data Source: EHR, Patient database Milestone 8 Estimated Incentive Payment: $407,112 **Milestone 9** [I-13]: New patients assigned to a medical home receive their first appointment in a timely manner Metric 1 [I-13.1]: Improve the number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days Goal: 15% improvement over baseline, 92% new patients assigned Data Source: EHR, Patient database Milestone 9 Estimated Incentive	**Milestone 10** [I-12]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric 1 [I-12.1]: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the performing provider. Goal: Improve 15% improvement over baseline Data Source: EHR, Patient database Milestone 10 Estimated Incentive Payment: $224,204 **Milestone 11**[I-13]: New patients assigned to a medical home receive their first appointment in a timely manner Metric 1 [I-13.1]: Improve the number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days Goal: 20% improvement over baseline, 96 % new patients assigned Data Source: EHR, Patient database

020943901.2.4	***2.1.1***	***2.1.1 (A-D)***	***ESTABLISH A MEDICAL HOME AT METROCREST CLINIC***	
	Medical City Dallas			*020943901*
Related Category 3 Outcome Measure(s):	*020943901.3.11*	*3 IT-11.5*	*All-cause Admission Rate for Chronically-ill patients in medical home*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 1 [I-12.1]: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the performing provider. Goal: establish baseline of number of patients currently eligible based on adopted critieria, estimated 70% Data Source: EHR, Patient database Milestone 3 Estimated Incentive Payment: $188,064 **Milestone 4** [I-13]: New patients assigned to a medical home receive first appointment in a timely manner Metric 1 [I-13.1]: Improve the number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days Goal: 80% new patients assigned Data Source: EHR, Patient database Milestone 4 Estimated Incentive Payment: $188,063	their first appointment in a timely manner Metric 1 [I-13.1]: Improve the number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days Goal:10 % improvement over baseline, 88% new patients assigned Data Source: EHR, Patient database Milestone 7 Estimated Incentive Payment: $256,270		Payment: $407,111	Milestone 11 Estimated Incentive Payment: $224,204 **Milestone 12** [I-18]: Obtain or maintain medical home recognition by a nationally recognized agency (e.g., NCQA) Metric 1 [I-18.1]: Medical home recognition/ accreditation plan implementation progress and/or achieved/maintained Goal: Achieve accreditation Data Source: Documentation of recognition/accreditation from nationally recognized agency (e.g., NCQA) Milestone 12 Estimated Incentive Payment: $224,204
Year 2 Estimated Milestone Bundle Amount: $752,254	Year 3 Estimated Milestone Bundle Amount: $768,810		Year 4 Estimated Milestone Bundle Amount: $814,223	Year 5 Estimated Milestone Bundle Amount: $672,612
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $3,007,899				

Project Option 2.2.2 - Expand Chronic Care Management Models

Unique Project ID: 126679303.2.1
Performing Provider Name/TPI: Methodist Charlton Medical Center/126679303

Provider: Methodist Charlton Medical Center is a 269-bed facility in southern Dallas County serving a 357 square mile area and a population of approximately 393,000.
Methodist Charlton Medical Center provides a full range of acute care services to broad range of patients with all types of injuries and diseases across the continuum of care. Other than transplants, all other medical specialties are represented at this facility. In the last year, thirty-nine percent of Methodist Charlton's patients were Medicaid eligible or uninsured representing $197 million in charges for those services.

Intervention: The primary purpose of this project is to develop and implement a chronic disease management intervention geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization.

This project is a new initiative because the hospital does not have standing orders for diabetes protocols, does not offer dedicated diabetes education on self-management and has not received any other federal funding for it.

Need for Project: Promoting effective change in provider settings to support evidence-based clinical and quality improvement across a wide variety of health care settings will make a significant improvement to the self-management of chronic conditions such as diabetes. CDC data indicates that almost half of all Americans, more than 145 million, live with a chronic condition. In the hospital market more than 10% of the population has been diagnosed with diabetes and the number is growing.

More than half of individuals with a chronic condition have multiple conditions. The challenge in the community due to the lack of proper self-management of chronic conditions is higher rates of illness, higher utilization of high cost services and lower quality of life.

Target Population: The target population is our ED patients that have either a principal or secondary diagnosis ofdiabetes and need education on managing diabetes and have high risk needs associated with diabetes based on clinical protocols of HbA1c >9.0%, at least one ED visit in the past 12 months and/or have not received diabetes education within the past five years. Our annual ED visits are approximately 72,000. Those diagnosed with diabetes as the primary or secondary diagnosis is 4,796.
Approximately 39% of our patients are either Medicaid eligible or indigent so we expect about 39% of the patients enrolled in the program to be Medicaid eligible or indigent.

Category 1 & 2 Expected Patient Benefit: I-17 Apply the chronic care model to targeted chronic diseases which are prevalent locally such as Diabetes. Of our target population, we expect 30%

to be eligible or in need of diabetes care model. Our baseline is zero as this a new program at the hospital. In DY3 the goal is to begin providing care through the new program with 10 new patients receiving care under the chronic care management program by 9/30/14, increasing that number to 1,439 in DY4 with an additional improvementof 5% over DY4 in DY5.

I-18 Improve the percentage of diabetic inpatients with self-management goals. The baseline is zero as this is a new program at the hospital. The project seeks to improve number of diabetic ED patients with self-management goals from 0 to 5% of the target population (those identified above as eligible for the chronic care managmenet program) or 72 patients in DY4 and an additional 5% to 144 patients in DY5.

Category 3 Outcome: IT-1.11 Diabetes care: Blood pressure control (<140/80mm Hg). Improvement Target: While the baseline is zero as this is a new program at the hospital, it is expected that 25% of the 1,439 eligible expected to be in the program of 360 patients will have controlled blood pressure. Therefore, in DY4, the goal is to increase the number of target patients in the program with controlled blood pressure by 1.5% and an additional improvement in DY5 of 1.5% over DY4.

- IT-1.10 Diabetes care: HbA1c poor control (>9.0%). Improvement Target: While the baseline is zero as this is a new program at the hospital, it is expected that 65% of the target population or 935 patients will have uncontrolled A1c levels. Therefore, in DY4, the goal is to decrease the number of target patients in the program with uncontrolled A1c levels by 1.5% with an additional decrease of 1.5% over DY4 in DY5.

- IT-3.3 Diabetes 30 day readmission rate. Improvement Target: The target population in DY4 for this program is expected to be 1,439 patients. Historically the diabetes readmission rate is 5.21%. Therefore, we expect the diabetes 30-day readmission rate among this target population to be 5.21% or 75 patients. Therefore, in DY4, the goal is to decrease diabetes 30-day readmissions to the hospital from this target population by 10% with an additional 10% reduction over DY4 in DY5.

These outcomes support the project's purpose because if we do a better job of keeping people's blood pressure and HbA1C levels within appropriate limits, it will lower readmissions and the cost associated with managing chronic conditions of our patients.

Project Description

This project will apply evidence-based care management models for ED patients identified as having high-risk health care needs associated with diabetes. The project will develop chronic disease management education, protocols and self-management criteria for patients through a multi-disciplinary process. These protocols, once developed will be implemented in the hospital

through new outpatient and inpatient education services, through the network of primary care physicians and made available to community clinics supporting diabetic patients. Historically, patients that do not effectively manage their diabetes tend to develop chronic diabetes complications, co-morbidities and lead to higher utilization and costs related to health care services. This program will be implemented to help those who need education on managing diabetes and providing monitoring services where they are being treated. Patients will be identified by partnering with primary care physicians, community clinics and inpatient nurse/care managers. Patients identified as having high risk needs associated with diabetes will be based on clinical protocols of A1C>9, at least on ED visit in the past 12 months and/or have not received diabetes education within the past five years.

Goals and Relationship to Regional Goals

The goal of this project is to develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. The purpose for implementing a chronic disease management program for diabetes is based on hospital and community data. Diabetes related diagnoses account for the third highest patient segment for readmissions to the hospital. Diabetes management is also one of the top five community health needs with over 10% of the Dallas county population having been diagnosed with diabetes. The development and implementation of chronic disease management interventions for diabetes will lower costs and improve outcomes for the diabetic patients and community health status.
A major goal of the region is to improve the rate of chronic disease self-management and education. This project will contribute to that goal by providing patient education resources based on clinical management protocols.

Challenges

Hospital and market data indicates that approximately 40% of ED outpatient visits and 30% of inpatients with diabetes are Medicaid and uninsured patients. In the northern portion of the hospital service area 31% of the population is Hispanic and represents the fastest growing population segment. Hispanics are 1.5 times as likely to develop diabetes as non-Hispanic populations according to the CDC. Effective communication and creativity in reaching this community demographic has been identified as a challenge for this project.

5-Year Expected Outcome for Provider and Patients

- Formed multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar
- Developed a comprehensive diabetes care management program

- Developed and implemented plan for standing orders for diabetes patients
- Trained staff in the Chronic Care Model, including essential components of a delivery system that supports high-quality clinical and chronic diabetes management, and on the standing orders for diabetes patients
- Developed and implemented OP Diabetes Education Clinic and IP Educator program to assist patients to better self-manage their chronic diabetes
- Improved number of patients with self-management goals
- Improved number of patients being treated under the Chronic Care Model and/or Standing Orders for Diabetes

Starting Point/Baseline

Diabetes related diagnoses account for the third highest patient segment for readmissions to the hospital. Diabetes management is also one of the top five community health needs with over 10% of the Tarrant county population having been diagnosed with diabetes. The hospital currently does not offer outpatient diabetes education clinic services or inpatient diabetes education. During DY2 and DY3 as the chronic health management program and clinical protocols for standing orders are developed, the target populations will begin to be identified. Historically, the ED has seen approximately 4,796 patients that also have a principal or secondary diagnosis of diabetes. We expect to target 30% of those with the program; 25% (or 360) are expected to have controlled blood pressure and 65% (or 935) uncontrolled A1c level >9.0%.

Rationale

Promoting effective change in provider settings to support evidence-based clinical and quality improvement across a wide variety of health care settings will make a significant improvement to the self-management of chronic conditions such as diabetes. CDC data indicates that almost half of all Americans, more than 145 million, live with a chronic condition. In the hospital market more than 10% of the population has been diagnosed with diabetes and the number is growing. More than half of individuals with a chronic condition have multiple conditions. The challenge in the community due to the lack of proper self-management of chronic conditions is higher rates of illness, higher utilization of high cost services and lower quality of life.

Project Components

The following core project components were selected because they are sequential steps necessary to implement the project and each is designed to apply evidence-based care management model to patients identified as having high-risk health care needs related to diabetes.

a. We will design and implement multi-disciplinary teams that are tailored to the patient's health care needs to include clinical nursing, physician representation as well as members from finance, patient education and existing employee medical home leadership.

b. Patients enrolled into the program will receive contact information from patient navigators to ensure that patients can access their care teams in person, phone or email

c. An integral part of this project is to provide patient education and self-management support. We will incorporate learnings from the hospital's current medical home and ACO initiatives to improve 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. We will conduct ongoing quality improvement efforts for the project. The hospital's quality committee of the board meets regularly to assess ongoing programs at the facility and will be used to evaluate the success and improvement opportunities of the chronic care management project as well.

An integral part of this project is to provide patient education and self-management support. We will incorporate learnings from the hospital's current medical home and ACO initiatives to improve patient provider communication techniques and coordination with community resources.

We will conduct ongoing quality improvement efforts for the project. The hospital's quality committee of the board meets regularly to assess ongoing programs at the facility and will be used to evaluate the success and improvement opportunities of the chronic care management project as well.

Currently we use the Plan Do Check Act version of quality improvement for all of our programs at the hospital. We incorporate this process into any new program we do so that we embark with proper planning and have the systems in place to identify improvement opportunities throughout all stages of implementation.

Unique Community Need Identification Numbers the Project Addresses

- CN.9: Chronic Care
- CN.12: ED Utilization and Readmissions

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

This project is a new initiative because the hospital does not have standing orders for diabetes protocols, does not offer dedicated diabetes education on self-management and has not received any other federal funding for it.

Related Category 3 Outcome Measure(s)

- IT-1.10: Diabetes Care: HbA1c poor control (>9.0%)
- IT-1.11: Diabetes Control: Blood pressure control (<140/80mm Hg
- IT-3.3: Diabetes 30-Day Readmission Rate

There are three Related Category 3 Outcome Measures for this project. The first two fall within Outcome Measure "Primary Care and Chronic Disease Management" (OD-1). Specifically the two Improvement Targets are IT-1.10 (Diabetes Care: HbA1c poor control (>9.0%)) and IT-1.11 (Diabetes Control: Blood pressure control (<140/80mm Hg)). This project will identify patients in the ED who that are identified as having poor diabetes control. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market ultimately leading to better diabetes control outcomes.

The third Related Category 3 Outcome Measure falls within the Outcome Measure "Potentially Preventable Re-Admissions – 30-Day Readmission Rates" and IT-3.3 Diabetes 30 day readmission rate. This project will identify ED patients who have poor diabetes control and ultimately at high risk for readmission to the hospital. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market. Better preparing patients for self-management, education and ongoing support for diabetes care will ultimately lead to reduced diabetic re-admissions from this target population.

Reasons/Rationale for selecting outcome measures

Our process milestones measure the development of chronic care management program for diabetes, training and education of care givers in multiple care sites, development of standing orders for diabetic patients and the development of a new Outpatient Diabetes Education service and new Inpatient Educator program. The Improvement milestones measure the number of individuals that will targeted for the education and self-management protocols, as well as the increased number of patients with self-management goals. The specific improvement targets for the number of patients provided services for education and the number of patients with self-management goals will be determined during DY2.

Relationship to Other Projects

Related projects regarding chronic care management include:

209345201.2.1 Methodist Richardson Medical Center
135032405.2.2 Methodist Dallas Medical Center

This project will support, reinforce and enable the following Category 4, Reporting Domains through the project design and intervention for appropriate targeted patients:

- RD-1. 2 (Preventable Admissions)-Diabetes Admission Rate
- RD-2.2 (Preventable 30 Day Re-Admissions)-Diabetes Re-Admission Rate
- RD-4.2 (Patient Centered Healthcare)-Medication Management

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

The RHP 9 projects regarding chronic care management are as follows:

Performing Provider	Unique Project	Project Option
Baylor University Medical Center	139485012.2.2	Expand Chronic Care Management Model – Diabetes (HbA1c poor control, BP control, foot exam)
Baylor Medical Center at Garland	121790303.2.2	
Baylor Medical Center at Irving	121776204.2.2	
Trinity Medical Center (Baylor-Carrollton)	195018001.2.1	
Children's Medical Center	138910807.1.3	Implement pediatric disease registry – asthma
Denton County HHS	13660803.2.1	Implement disease registry – diabetes
Methodist Charlton Medical Center	126679303.2.1	Expand Chronic Care Management Model – Diabetes (30-day readmission, Hba1c, BP control)
Methodist Dallas Medical Center	135032405.2.1	
Methodist Richardson Medical Center	209345201.2.1	
Parkland Health & Hospital System	127295703.1.3	Implement chronic care registry (Diabetes – retinal eye exam, 30-day readmissions)
Parkland Health &Hospital System	127295703.2.4	Expand Chronic Care Management Model – Diabetes (retinal eye exam; 30-day readmissions)
Texas Health Presbyterian Hospital Denton	020967801.2.2	Expand Chronic Care Management Model: Diabetes

Texas Health Presbyterian Hospital Kaufman	094140302.2.2	(HbA1c poor control, 30 day readmissions)
UTSW – Faculty Practice Plan	126686802.2.2	Expand Chronic Care Management Model (Diabetes: HbA1c poor control; All Cause Readmissions)

Plan for Learning Collaborative: We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

126679303.2.1	*2.2.2*	*2.2.2*	***Title:** Expand Chronic Care Management Models*	
Performing Provider: Methodist Charlton Medical Center				*TPI: 126679303*
Related Category 3 Outcome Measures :	*126679303.3.1* *126679303.3.2* *126679303.3.3*	*IT-1.11* *IT-1.10* *IT-3.3*	*Diabetes Care: Blood Pressure control* *Diabetes Care: HbA1c poor control* *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-4] Formalize multi-disciplinary teams, pursuant to the chronic care model defined by Wagner Chronic Care Model. Metric 1 [P-4.1]: Increase the number of multi-disciplinary teams Baseline = 0/Goal = 1 Data Source: Administrative records Milestone 1 Estimated Incentive Payment (max amount): $568,067 **Milestone 2** [P-3] Develop a comprehensive care management program. Metric 2 [P-3.1]: Documentation of plan Baseline = 0 /Goal: care management document Data Source: Administrative records Milestone 2 Estimated Incentive Payment (max amount): $568,066		**Milestone 3** [P-12] Develop and implement plan for standing orders Metric 1 [P-12.1] Documentation of plan for standing orders Baseline = 0 /Goal: care mgt document Data Source: Administrative records Milestone 3 Estimated Incentive Payment (max amount): $413,153 **Milestone 4** [P-2] Train staff on Chronic Care Model, including essential components of delivery system that supports high-quality clinical/chronic disease care Develop and implement plan for standing orders Metric 1 [P-2.1] Percent of staff trained Baseline/Goal: 0% / 5% Data Source: Administrative records Milestone 4 Estimated Incentive Payment (max amount): $413,153 **Milestone 5** [P-11] Develop and	**Milestone 6** [I-17] Apply the Chronic Care Model to targeted chronic diseases which are prevalent locally, such as diabetes Metric 1 [I-17.1]: Percent of diabetic ED patients receiving care under the Chronic Care model Baseline: 10 / Goal: 1,439 Data Source: Administrative records Milestone 6 Estimated Incentive Payment (max amount): $621,531 **Milestone 7** [I-18] Improve the percentage of diabetic inpatients with self-management goals Metric 1 [I-18.1]: Diabetic ED patients with self-management goals Baseline: 0 / Goal: 72 Data Source: Administrative records Milestone 7 Estimated Incentive Payment (max amount): $621,532	**Milestone 8** [I-17] Apply the Chronic Care Model to targeted chronic diseases which are prevalent locally, such as diabetes Metric 1 [I-17.1]: Percent of diabetic ED patients receiving care under the Chronic Care model Baseline: 1,439 / Goal: increase of 5% over DY4 Data Source: Administrative records Milestone 8 Estimated Incentive Payment (max amount): $513,439 **Milestone 9** [I-18] Improve the percentage of diabetic ED patients with self-management goals Metric 1 [I-18.1]: Diabetic ED patients with self-management goals Baseline: 72 / Goal: 144 Data Source: Administrative records

126679303.2.1	*2.2.2*	*2.2.2*	***Title:*** *Expand Chronic Care Management Models*	
Performing Provider: Methodist Charlton Medical Center				*TPI: 126679303*
Related Category 3 Outcome Measures :	*126679303.3.1* *126679303.3.2* *126679303.3.3*	*IT-1.11* *IT-1.10* *IT-3.3*	*Diabetes Care: Blood Pressure control* *Diabetes Care: HbA1c poor control* *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)**
		implement program to assist patient to better self-manage their chronic conditions <u>Metric 1</u> [P-11.1] Increase the number of patients enrolled in a self-management program Baseline/Goal: 0 /10 by 9/30/2014 Data Source: Administrative records Milestone 5 Estimated Incentive Payment (max amount): $413,154		Milestone 9 Estimated Incentive Payment (max amount): $513,440
Year 2 Estimated Milestone Bundle Amount (add incentive payment amounts from each milestone): $1,136,133		**Year 3 Estimated Milestone Bundle Amount:** $1,239,460	**Year 4 Estimated Milestone Bundle Amount:** $1,243,063	**Year 5 Estimated Milestone Bundle Amount:** $1,026,879
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $4,645,535				

Project Option 2.9.1 - Establish/Expand a Patient Care Navigation Program

Unique Project ID: 126679303.2.2
Performing Provider Name/TPI: Methodist Charlton Medical Center/126679303

Provider: Methodist Charlton Medical Center is a 269-bed facility in southern Dallas County serving a 357 square mile area and a population of approximately 393,000.
Methodist Charlton Medical Center provides a full range of acute care services to broad range of patients with all types of injuries and diseases across the continuum of care. Other than transplants, all other medical specialties are represented at this facility. In the last year, thirty-nine percent of Methodist Charlton's patients were Medicaid eligible or uninsured representing $197 million in charges for those services.

Intervention: To provide patient navigation services in the Emergency Room to patients who are at high risk of disconnecting from institutionalized health care services or are identified as not having a primary care physician and/or medical home to address their needs. This project will identify frequent ED users and use navigators as part of a preventable ED reduction program. This project will connect patients to primary and preventative care and increase access to care management and/or chronic care management which should improve unnecessary ED utilization as well as the health condition of those most at risk for costly chronic conditions.

This project is a new initiative because the hospital does not provide patient navigation services in the ED currently and has not received any other federal funding for it.

Need for Project: A major goal of the region is to reduce the unnecessary utilization in the Emergency Departments of the DFW hospitals. This project will contribute to that goal by providing patient navigation resources that would identify patients that are eligible to receive care in a more appropriate setting. This project will impact a specific portion of the population in the region as well as provide a knowledge base that could be applied to other regional hospitals.

Target Population: The target population is frequent users of the emergency department, defined as six or more visits per year, estimated to be 8.6% of total ED visits, or 6,210 patients per year. Approximately 49% of our ED patients are either Medicaid eligible or indigent so we expect nearly half of the patients helped by the program to be Medicaid eligible or indigent.

Category 1 & 2 Expected Patient Benefit: I-6 Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services. Improvement Target: Baseline will be established in DY3, which is expected to be 6,210 targeted patients identified as frequent users of ED services. The project seeks to refer at least 50% of this target population or 3,105 to a more appropriate primary care setting for follow up care in DY4 and 70% of the original baseline referred to primary care in DY5. I-8 Reduction in ED use by identified ED frequent users receiving navigation. Improvement Target: Baseline will be

established in DY3 which is expected to be 3,105. The project seeks to realize a 2.5% reduction over baseline expected in DY4 and an additional improvement of 2.5% of the prior year in DY5.

Category 3 Outcome: IT-9.2 Appropriate ED Utilization. Improvement Target: Baseline will be established in DY3 which is expected to be 3,105. Decrease utilization of ED patients from baseline by 2.5% in DY4 and an additional reduction of 2.5% over prior year in DY5.

IT-3.1 All cause 30 day readmission rate. Improvement Target: Baseline will be established in DY3 which is expected to be 554. Decrease readmissions to the hospital from targeted baseline population by 2.5% in DY4 and an additional reduction of 2.5% over prior year in DY5.

These improvement milestones and outcomes support the project's objective to reduce utilization of high cost ED settings by placing frequent users of the emergency department into a more appropriate care setting.

Project Description

This project will provide patient navigation services in the Emergency Room to targeted patients who are at high risk of disconnecting from institutionalized health care services or are identified as not having a primary care physician and/or medical home to address their needs. This project will identify frequent ED users and use navigators as part of a preventable ED reduction program. This project will increase the number of people trained and deployed for innovative health services such as social workers. This project will connect patients to primary and preventative care and increase access to care management and/or chronic care management. This project should improve the utilization of unnecessary ED utilization as well as improve the health condition of those most at risk for costly chronic conditions.

Goals and Relationship to Regional Goals

The goal of this project is to utilize community health workers, case managers or other types of healthcare professionals as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient navigators will help and support these patients to navigate through the continuum of care services. Patient Navigators will ensure that patients receive timely, coordinated and site appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the ED to site-appropriate locations. Implementing this project will identify health care workers, case managers or other types of health professionals needed to engage with patients in a culturally and linguistically appropriate manner that will be essential to guiding the patients through the integrated health care delivery systems.

A major goal of the region is to reduce the unnecessary utilization in the Emergency Departments of the DFW hospitals. This project will contribute to that goal by providing patient navigation resources that would identify patients that are eligible to receive care in a more

appropriate setting. This project will impact a specific portion of the population in the region as well as provide a knowledge base that could be applied to other regional hospitals.

Challenges

Emergency Departments have become a vital source of care for those without insurance who generally lack a source of primary care, since they are required to evaluate and treat patients regardless of the ability to provide payment. Consequently, although care delivered through the ED is frequently for non-urgent problems, it is substantially more costly than care delivered in a more appropriate setting. DFW and National data indicate that the 26% of non-elderly individuals that are without health insurance exceeds the nearly 19% nationally of non-elderly individuals are without health insurance. These rates increase for individuals with lower incomes. Minority and low-income individuals without insurance generally lack a regular source of medical care, and suffer from medical conditions that are either preventable or easily treated in the outpatient setting. Consequently, the uninsured are four times more likely than the insured to forgo or postpone needed preventative care. The ED has become a societal solution for those with chronic conditions and/or lacking access to primary care. The patient navigation project will be focused on overcoming these societal challenges. Additional challenges will include the acquisition of professional resources that have a background and training to provide social services and navigation care services, as well as overcoming the reliance on personal accountability of the patient to follow up with a provider in a more appropriate care setting.

5-Year Expected Outcome for Provider and Patients

The expected outcomes for the patient navigation project are to:

- Identified frequent ED users and use of navigators as part of preventable ED reduction program.
- Trained health care navigators in cultural competency.
- Deployed innovative health care personnel such as case managers/workers, community health workers and other types of health professionals as patient navigators.
- Connected patients to primary and preventative care.
- Increased access to care management and/or chronic care management, including education in chronic disease self-management.
- Decreased of inappropriate ED utilizations.

<u>Starting Point/Baseline</u>

Currently the baseline is zero. During DY2 frequent ED users will be identified based on a needs assessment to identify the patient population for which the program will be targeted. Patient navigation and care management will be provided to these patients. DY3 will serve as the baseline period for the project. Based on the number of patients served by the project, the number of providers trained to support the program will be identified and implemented

Rationale

Emergency Department utilization in North Texas exceeds national utilization rates resulting in higher costs for providing care to the region. The Community Health Needs Assessment points to a lack of accessing primary care sites and the inability to redirect patients to a more appropriate care setting. The patient navigator project will provide resources to help patients and their families better locate and navigate appropriate care locations.

Project Components

The following core project components were selected because each component is designed to provide and improve navigation services to targeted patients who are at high risk of disconnect from institutionalized health care:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators

c) Connect patients to primary and preventative care

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management

e) We will conduct ongoing quality improvement efforts for the project. The hospital's quality committee of the board meets regularly to assess ongoing programs at the facility and will be used to evaluate the success and improvement opportunities of the chronic care management project as well.

Currently we use the Plan Do Check Act version of quality improvement for all of our programs at the hospital. We incorporate this process into any new program we do so that we embark with proper planning and have the systems in place to identify improvement opportunities throughout all stages of implementation.

Unique Community Need Identification Numbers the Project Addresses

- CN.1: Demographics

- CN.2: Healthcare Infrastructure
- CN.8: Specialty Care
- CN.10: Oral Health
- CN.11: Patient Safety and Quality
- CN.13: Palliative Care

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

This project is a new initiative because the hospital does not provide patient navigation services in the ED currently and has not received any other federal funding for it.

Related Category 3 Outcome Measure(s)

There are two Related Category 3 Outcome Measures for this project. The first is Outcome Measure "Right Care, Right Setting" (OD-9) and IT-9.2 ED Utilization. Specifically there will be a reduction in all ED visits if the patient navigation program is effective. By identifying frequent users of the ED and providing navigation services, these patients will be exposed to alternative care locations that would be more effective for managing their non-urgent health conditions and health need. The IT-9.2 measures is the most appropriate indicator to assess the results of care experienced by patients, including patients' clinical events, patients' recovery and health status, patients' experiences in the health system, and efficiency/cost.
The second is Outcome Measure "Potentially Preventable Re-Admissions – 30 Day Readmission Rates" and IT-3.1 All cause 30 day readmission rate. The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the lack of chronic disease management and lack of access to appropriate sites of care. The patient navigator program will re-direct patients from the ED to a more appropriate care setting, where management of chronic conditions will be better suited. A reduction in frequent ED users and access to better care site for chronic conditions will lead to a reduction in readmission rates for those enrolled in the program.

Reasons/Rationale for selecting outcome measures

Our milestones measure the reduction in the number of patients that frequently use the ED; 1) we are increasing the number of patients identified as frequent users of the ED, 2) increasing the number of patient navigators available to provide services to those patients, and 3) increasing the number of patients referred to more appropriate care settings. As a result of these efforts, there will be a reduction in the number of ED visits by those enrolled in the program 5% by DY5. These milestones will measure whether we have increased the number of frequent ED users that are provided navigation services, increased the number of patient navigation resources, and as a result, decreased inappropriate ED utilization.

Relationship to Other Projects

135032405.2.3 Methodist Dallas Medical Center
209345201.2.2 Methodist Richardson Medical Center

This project will support, reinforce and enable the following Category 4, Reporting Domains through the project design and intervention for appropriate targeted patients:

- RD-1.1 (Preventable Admissions)-CHF Admission Rate
- RD-1.2 (Preventable Admissions)-Diabetes Admission Rate
- RD-1.4 (Preventable Admissions)-COPD/Asthma Admission Rate
- RD-1.5 (Preventable Admissions)-Hypertension Admission Rate
- RD-2.1 (Preventable 30 Day Re-Admissions)-CHF Re-Admission Rate
- RD-2.2 (Preventable 30 Day Re-Admissions)-Diabetes Re-Admission Rate
- RD-2.4 (Preventable 30 Day Re-Admissions)-COPD/Asthma Re-Admission Rate
- RD-2.5 (Preventable 30 Day Re-Admissions)-Hypertentsion Re-Admission Rate

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives
The RHP 9 projects related to patient navigation are as follows:

Performing Provider	Unique Project
Baylor Medical Center at Garland	121790303.2.4
Baylor Medical Center at Irving	121776204.2.4
Baylor University Medical Center	139485012.2.3
Children's Medical Center	138910807.2.3
Medical Center of Lewisville (HCA)	094192402.2.3
Methodist Charlton Medical Center	126679303.2.2
Methodist Dallas Medical Center	135032405.2.3
Methodist Richardson Medical Center	209345201.2.2
Parkland Health & Hospital System	127295703.2.7
Texas Health Presbyterian – Denton	020967801.2.1
Texas Health Presbyterian – Kaufman	094140302.2.1
University of Texas Southwestern	126686802.2.4

Plan for Learning Collaborative: We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

126679303.2.2	*2.9.1*	*2.9.1 (a-e)*	***Title: ESTABLISH A PATIENT CARE NAVIGATION PROGRAM***	
		Methodist Charlton Medical Center		*TPI: 126679303*
Related Category 3 Outcome Measures:	*126679303.3.4* *126679303.3.5*	*IT-9.2* *IT-3.1*	*ED Appropriate Utilization* *All Cause 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)**
Milestone 1 [P-2] Establish 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 navigation education. Metric 1 [P-2.1]: Number of people trained as patient navigator Baseline = 0/Goal = 1 Data Source: Administrative records Milestone 1 Estimated Incentive Payment (max amount): $1,054,981 **Milestone 2** [P3] Provide care management/ navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Baseline = 0 /Goal: Start program to see first patient by 9/30/2013 Data Source: Administrative records Milestone 2 Estimated Incentive		**Milestone 3** [P-2] Establish 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 navigation education. Metric 1 [P-2.1] Number of people trained as patient navigator Baseline = 1/Goal = 2 Data Source: Administrative records Milestone 3 Estimated Incentive Payment (max amount): $1,150,927 **Milestone 4** [P-3] Provide care management/ navigation services to targeted patients. Metric 1 [P-3.1] Increase in number or percent of targeted patients enrolled in program Baseline = 1 /Goal: 3,105 Data Source: Administrative records Milestone 4 Estimated Incentive Payment (max amount): $1,150,928	**Milestone 5** [I-6] Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services. Metric 1 [I-6.3]: Percent of patients without a primary care provider who are referred to a primary care provider in ED. Baseline: 0 / Goal: 50% of targeted patients in the program or 1,553 Data Source: Administrative records Milestone 5 Estimated Incentive Payment (max amount): $1,154,273 **Milestone 6** [I-8] Reduction in ED use by identified ED frequent users receiving navigation services. Metric 1 [I-8.1]: ED visits pre- and post-navigation services by individuals identified as ED frequent users Baseline: 3,105 / Goal: 2.5% reduction from baseline Data Source: Administrative records Milestone 6 Estimated Incentive Payment (max amount): $1,154,274	**Milestone 7** [I-6] Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services. Metric 1 [I-6.3] Percent of patients without a primary care provider who are referred to a primary care provider in the ED. Baseline: 1,553 / Goal: 70% of original baseline or 2,174. Data Source: Administrative records Milestone 7 Estimated Incentive Payment (max amount): $953,530 **Milestone 8** [I-8] Reduction in ED use by identified ED frequent users receiving navigation services. Metric 1 [I-8.1]: ED visits pre- and post-navigation services by individuals identified as ED frequent users Baseline: 2.5% of baseline (3,027) / Goal: additional reduction of 2.5% (2,951) over prior year DY4

126679303.2.2	*2.9.1*	*2.9.1 (a-e)*	***Title: ESTABLISH A PATIENT CARE NAVIGATION PROGRAM***	
Methodist Charlton Medical Center				*TPI: 126679303*
Related Category 3 Outcome Measures:	*126679303.3.4* *126679303.3.5*	*IT-9.2* *IT-3.1*	*ED Appropriate Utilization* *All Cause 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)**
Payment (max amount): $1,054,981				Data Source: Administrative records Milestone 8 Estimated Incentive Payment (max amount): $953,531
Year 2 Estimated Milestone Bundle Amount : $2,109,962		**Year 3 Estimated Milestone Bundle Amount:** $2,301,855	**Year 4 Estimated Milestone Bundle Amount:** $2,308,547	**Year 5 Estimated Milestone Bundle Amount:** $1,907,061
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $8,627,425				

2.9.1 Establish/Expand a Patient Care Navigation Program

Unique Project ID: 135032405.2.1
Performing Provider Name/TPI: Methodist Dallas Medical Center/ 135032405

Provider: Methodist Dallas Medical Center is a 515-bed facility in southern Dallas County serving a 537 square mile area and a population of approximately 1,019,000.
Methodist Dallas Medical Center is a designated safety net hospital and the only Level 2 trauma center located in its service area, providing a full range of acute care services to broad range of patients with all types of injuries and diseases across the continuum of care. In the last year, forty-five percent of Methodist Dallas' patients were Medicaid eligible or uninsured representing $327 million in charges for those services.

Intervention: To provide patient navigation services in the Emergency Room to patients who are at high risk of disconnecting from institutionalized health care services or are identified as not having a primary care physician and/or medical home to address their needs. This project will identify frequent ED users and use navigators as part of a preventable ED reduction program. This project will connect patients to primary and preventative care and increase access to care management and/or chronic care management which should improve unnecessary ED utilization as well as the health condition of those most at risk for costly chronic conditions.

This project is a new initiative because the hospital does not provide patient navigation services in the ED currently and has not received any other federal funding for it.

Need for the Project: A major goal of the region is to reduce the unnecessary utilization in the Emergency Departments of the DFW hospitals. This project will contribute to that goal by providing patient navigation resources that would identify patients that are eligible to receive care in a more appropriate setting. This project will impact a specific portion of the population in the region as well as provide a knowledge base that could be applied to other regional hospitals.

Target Population: The target population is frequent users of the emergency department, defined as six or more visits per year, estimated to be 8.5%-9% of total ED visits, or 5,200 patients per year.

Approximately 56% of our ED patients are either Medicaid eligible or indigent so we expect about 56% of the patients helped by the program to be Medicaid eligible or indigent.

Category 1 & 2 Expected Patient Benefit: I-6 Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services. Improvement Target: Baseline will be established in DY3, which is expected to be 5,200 targeted patients identified as frequent users of ED services. The project seeks to refer at least 50% of this target

population or 2,600 to a more appropriate primary care setting for follow up care in DY 4 and 70% of the original baseline referred to primary care in DY5.
I-8 Reduction in ED use by identified ED frequent users receiving navigation. Improvement Target: Baseline will be established in DY3 which is expected to be 2,600. The project seeks to realize a 2.5%reduction over baseline expected in DY4 and an additional improvement of 2.5% over the prior year in DY5.

Category 3 Outcome:

IT-9.2 Appropriate ED Utilization. Improvement Target: Baseline will be established in DY3 which is expected to be 2,600. Decrease utilization of ED patients from baseline by 2.5% in DY4 and an additional reduction of 2.5% over prior year in DY5.

IT-3.1 All cause 30 day readmission rate. Improvement Target: Baseline will be established in DY3 which is expected to be 465. Decrease readmissions to the hospital from targeted baseline population by 2.5% in DY4 and an additional reduction of 2.5% over prior year in DY5.

These improvement milestones and outcomes support the project's objective to reduce utilization of high cost ED settings by placing frequent users of the emergency department into a more appropriate care setting.

Project Description

This project will provide patient navigation services in the Emergency Room to targeted patients who are at high risk of disconnecting from institutionalized health care services or are identified as not having a primary care physician and/or medical home to address their needs. This project will identify frequent ED users and use navigators as part of a preventable ED reduction program. This project will increase the number of people trained and deployed for innovative health services such as social workers. This project will connect patients to primary and preventative care and increase access to care management and/or chronic care management. This project should improve the utilization of unnecessary ED utilization as well as improve the health condition of those most at risk for costly chronic conditions.

Goals and Relationship to Regional Goals

The goal of this project is to utilize community health workers, case managers or other types of healthcare professionals as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient navigators will help and support these patients to navigate through the continuum of care services. Patient Navigators will ensure that patients receive timely, coordinated and site appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the ED to site-appropriate locations. Implementing this project will identify health care workers, case managers or other types of

health professionals needed to engage with patients in a culturally and linguistically appropriate manner that will be essential to guiding the patients through the integrated health care delivery systems.

A major goal of the region is to reduce the unnecessary utilization in the Emergency Departments of the DFW hospitals. This project will contribute to that goal by providing patient navigation resources that would identify patients that are eligible to receive care in a more appropriate setting. This project will impact a specific portion of the population in the region as well as provide a knowledge base that could be applied to other regional hospitals.

Challenges

Emergency Departments have become a vital source of care for those without insurance who generally lack a source of primary care, since they are required to evaluate and treat patients regardless of the ability to provide payment. Consequently, although care delivered through the ED is frequently for non-urgent problems, it is substantially more costly than care delivered in a more appropriate setting. DFW and National data indicate that the 26% of non-elderly individuals that are without health insurance exceeds the nearly 19% nationally of non-elderly individuals are without health insurance. These rates increase for individuals with lower incomes. Minority and low-income individuals without insurance generally lack a regular source of medical care, and suffer from medical conditions that are either preventable or easily treated in the outpatient setting. Consequently, the uninsured are four times more likely than the insured to forgo or postpone needed preventative care. The ED has become a societal solution for those with chronic conditions and/or lacking access to primary care. The patient navigation project will be focused on overcoming these societal challenges. Additional challenges will include the acquisition of professional resources that have a background and training to provide social services and navigation care services, as well as overcoming the reliance on personal accountability of the patient to follow up with a provider in a more appropriate care setting.

5-Year Expected Outcome for Provider and Patients

The expected outcomes for the patient navigation project are to:

- Identified frequent ED users and use of navigators as part of preventable ED reduction
- Trained health care navigators in cultural competency.
- Deployed innovative health care personnel such as case managers/workers, community health workers and other types of health professionals as patient navigators.
- Connected patients to primary and preventative care.
- Increased access to care management and/or chronic care management, including education in chronic disease self-management.
- Decreased of inappropriate ED utilizations.

Starting Point/Baseline

Currently the baseline is zero. During DY2 frequent ED users will be identified based on a needs assessment to identify the patient population for which the program will be targeted. Patient navigation and care management will be provided to these patients. DY3 will serve as the baseline period for the project. Based on the number of patients served by the project, the number of providers trained to support the program will be identified and implemented.

Rationale

Emergency Department utilization in North Texas exceeds national utilization rates resulting in higher costs for providing care to the region. The Community Health Needs Assessment points to a lack of accessing primary care sites and the inability to redirect patients to a more appropriate care setting. The patient navigator project will provide resources to help patients and their families better locate and navigate appropriate care locations.

Project Components

The following core project components were selected because each component is designed to provide and improve navigation services to targeted patients who are at high risk of disconnect from institutionalized health care:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators

c) Connect patients to primary and preventative care

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management

e) We will conduct ongoing quality improvement efforts for the project. The hospital's quality committee of the board meets regularly to assess ongoing programs at the facility and will be used to evaluate the success and improvement opportunities of the chronic care management project as well.

Currently we use the Plan Do Check Act version of quality improvement for all of our programs at the hospital. We incorporate this process into any new program we do so that we embark with proper planning and have the systems in place to identify improvement opportunities throughout all stages of implementation.

Reasons/Rationale for selecting outcome measures

Our milestones measure the reduction in the number of patients that frequently use the ED; 1) we are increasing the number of patients identified as frequent users of the ED, 2) increasing the number of patient navigators available to provide services to those patients, and 3) increasing the number of patients referred to more appropriate care settings. As a result of these efforts, there will be a reduction in the number of ED visits by those enrolled in the program by 5% by DY5. These milestones will measure whether we have increased the number of frequent ED users that are provided navigation services, increased the number of patient navigation resources, and as a result, decreased inappropriate ED utilization.

Unique Community Need Identification Numbers the Project Addresses

- CN1 Demographics
- CN2 Health care infrastructure
- CN8 Specialty Care
- CN9 Chronic Disease
- CN11 Patient Safety & Quality
- CN13 Palliative Care

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

This project is a new initiative because the hospital does not provide patient navigation services in the ED currently and has not received any other federal funding for it.

Related Category 3 Outcome Measure(s)

There are two Related Category 3 Outcome Measures for this project. The first is Outcome Measure "Right Care, Right Setting" (OD-9) and IT-9.2 ED Utilization. Specifically there will be a reduction in all ED visits if the patient navigation program is effective. By identifying frequent users of the ED and providing navigation services, these patients will be exposed to alternative care locations that would be more effective for managing their non-urgent health conditions and health need. The IT-9.2 measures is the most appropriate indicator to assess the results of care experienced by patients, including patients' clinical events, patients' recovery and health status, patients' experiences in the health system, and efficiency/cost.

The second is Outcome Measure "Potentially Preventable Re-Admissions – 30 Day Readmission Rates" and IT-3.1 All cause 30 day readmission rate. The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the lack of chronic disease management and lack of access to appropriate sites of care. The patient navigator program will

re-direct patients from the ED to a more appropriate care setting, where management of chronic conditions will be better suited. A reduction frequent ED users and access to better care site for chronic conditions will lead to a reduction in readmission rates for those enrolled in the program.

Relationship to Other Projects

Methodist Charlton Medical Center	126679303.2.2
Methodist Richardson Medical Center	209345201.2.2

Related Category 4 Population-focused improvements

This project will support, reinforce and enable the following Category 4, Reporting Domains through the project design and intervention for appropriate targeted patients:

- RD-1.1 (Preventable Admissions)-CHF Admission Rate
- RD-1.2 (Preventable Admissions)-Diabetes Admission Rate
- RD-1.4 (Preventable Admissions)-COPD/Asthma Admission Rate
- RD-1.5 (Preventable Admissions)-Hypertension Admission Rate
- RD-2.1 (Preventable 30 Day Re-Admissions)-CHF Re-Admission Rate
- RD-2.2 (Preventable 30 Day Re-Admissions)-Diabetes Re-Admission Rate
- RD-2.4 (Preventable 30 Day Re-Admissions)-COPD/Asthma Re-Admission Rate
- RD-2.5 (Preventable 30 Day Re-Admissions)-Hypertentsion Re-Admission Rate

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

The RHP 9 projects related to patient navigation are as follows:

Performing Provider	Unique Project
Baylor Medical Center at Garland	121790303.2.3
Baylor Medical Center at Irving	121776204.2.3
Baylor University Medical Center	139485012.2.3
Children's Medical Center	138910807.2.3
Medical Center of Lewisville (HCA)	094192402.2.3
Methodist Charlton Medical Center	126679303.2.2
Methodist Dallas Medical Center	135032405.2.1
Methodist Richardson Medical Center	209345201.2.1
Parkland Health & Hospital System	127295703.2.7
Texas Health Presbyterian – Denton	020967801.2.1
Texas Health Presbyterian – Kaufman	094140302.2.1
University of Texas Southwestern – Faculty	126686802.2.4
University of Texas Southwestern – Hospital	175287501.2.1

Plan for Learning Collaborative: We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

135032405.2.1	*2.9.1*	*2.9.1 (A- E)*	*Title: ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM*	
Methodist Dallas Medical Center				*135032405*
Related Category 3 Outcome Measures :	*135032405.3.1* *135032405.3.2*	*IT-3.1* *IT-9.2*	*All Cause Readmissions* *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] Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected/fragmented care including program to train the navigators, develop procedures and establish continuing education. Metric 1 [P-2.1]: Number trained as patient navigator Baseline = 0/Goal = 1 Data Source: Administrative records Milestone 1 Estimated Incentive Payment (max amount): $1,758,834 **Milestone 2** [P-3] Provide care management/ navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Baseline = 0 /Goal: Start program to see first patient by 9/30/2013 Data Source: Administrative records Milestone 2 Estimated Incentive Payment (max amount): $1,758,834	**Milestone 3** [P-2] Establish 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 education. Metric 1 [P-2.1] Number of people trained as patient navigator Baseline = 1/Goal = 2 Data Source: Administrative records Milestone 3 Estimated Incentive Payment (max amount): $1,918,794 **Milestone 4** [P-3] Provide care management/ navigation services to targeted patients. Metric 1 [P-3.1] Increase in the number or percent of targeted patients enrolled in the program Baseline = 1 /Goal: 2,600 Data Source: Administrative records Milestone 4 Estimated Incentive Payment (max amount): $1,918,794	**Milestone 5** [I-6] Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services. Metric 1 [I-6.3]: Percent of patients without a primary care provider who are referred to a primary care provider in the ED. Baseline: 0 /Goal: 50% of targeted patients in the program or 1,300 Data Source: Administrative records Milestone 5 Estimated Incentive Payment (max amount): $1,924,372 **Milestone 6** [I-8] Reduction in ED use by identified ED frequent users receiving navigation services. Metric 1 [I-8.1]: ED visits pre- and post-navigation services by individuals identified as ED frequent users Baseline: 2,600 /Goal: 2.5% reduction from baseline. Data Source: Administrative records	**Milestone 7** [I-6] Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services. Metric 1 [I-6.3] Percent of patients without a primary care provider who are referred to a primary care provider in the ED. Baseline/Goal: 1,300 /70% of the original baseline or 1,820. Data Source: Administrative records Milestone 7 Estimated Incentive Payment (max amount): $1,589,699 **Milestone 8** [I-8] Reduction in ED use by identified ED frequent users receiving navigation services. Metric 1 [I-8.1]: ED visits pre- and post-navigation services by individuals identified as ED frequent users Baseline/Goal: 2.5% of baseline/ additional reduction of 2.5% over

135032405.2.1	*2.9.1*	*2.9.1 (A- E)*	*Title: ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM*	
Methodist Dallas Medical Center				*135032405*
Related Category 3 Outcome Measures :	*135032405.3.1* *135032405.3.2*	*IT-3.1* *IT-9.2*	*All Cause Readmissions* *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 6 Estimated Incentive Payment (max amount): $1,924,372	prior year DY4. Data Source: Administrative records Milestone 8 Estimated Incentive Payment (max amount): $1,589,699	
Year 2 Estimated Milestone Bundle: $3,517,668	**Year 3 Estimated Milestone Bundle Amount:** $3,837,588	**Year 4 Estimated Milestone Bundle Amount:** $3,848,744	**Year 5 Estimated Milestone Bundle Amount:** $3,179,398	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $14,383,398				

Project Option 2.2.2 – Expand Chronic Care Management Models

Unique Project ID: 135032405.2.2
Performing Provider Name/TPI: Methodist Dallas Medical Center/135032405

Provider: Methodist Dallas Medical Center is a 515-bed facility in southern Dallas County serving a 537 square mile area and a population of approximately 1,019,000.
Methodist Dallas Medical Center is a designated safety net hospital and the only Level 2 trauma center located in its service area, providing a full range of acute care services to broad range of patients with all types of injuries and diseases across the continuum of care. In the last year, forty-five percent of Methodist Dallas' patients were Medicaid eligible or uninsured representing $327 million in charges for those services.

Intervention: The primary purpose of this project is to develop and implement a chronic disease management intervention geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization.
This project is a new initiative because the hospital does not have standing orders for diabetes protocols, does not offer dedicated diabetes education on self-management and has not received any other federal funding for it.

Need for the Project: Promoting effective change in provider settings to support evidence-based clinical and quality improvement across a wide variety of health care settings will make a significant improvement to the self-management of chronic conditions such as diabetes. CDC data indicates that almost half of all Americans, more than 145 million, live with a chronic condition. In the hospital market more than 10% of the population has been diagnosed with diabetes and the number is growing.
More than half of individuals with a chronic condition have multiple conditions. The challenge in the community due to the lack of proper self-management of chronic conditions is higher rates of illness, higher utilization of high cost services and lower quality of life.

Target Population: The target population is our ED patients that have either a principal or secondary diagnosis of diabetes and need education on managing diabetes and have high risk needs associated with diabetes based on clinical protocols of HbA1c >9.0%, at least on ED visit in the past 12 months and/or have not received diabetes education within the past five years. Our annual ED visits are approximately 62,000. Those diagnosed with diabetes as the primary or secondary diagnosis is 5,360.

Approximately 45% of our patients are either Medicaid eligible or indigent so we expect about 45% of the patients enrolled in the program to be Medicaid eligible or indigent.

Category 1 & 2 Expected Patient Benefit: I-17 Apply the chronic care model to targeted chronic diseases which are prevalent locally such as Diabetes. Of our target population, we expect 30% to be eligible or in need of a diabetes care model. Our baseline is zero as this is a new program

at the hospital. In DY3 the goal is to begin providing care through the new program with 10 new patients receiving care under the chronic care management program by 9/30/14, increasing that number to 1,608 in DY4 with an additional improvement of 5% over DY4 in DY5.

I-18 Improve the percentage of diabetic inpatients with self-management goals. The baseline is zero as this is a new program at the hospital. The project seeks to improve number of diabetic ED patients with self-management goals from 0 to 5% of the target population (those identified above as eligible for the chronic care management program), or 80 patients in DY4 and an additional 5% or 160 patients by DY5.

Category 3 Outcome: IT-1.11 Diabetes care: Blood pressure control (<140/80mm Hg). Improvement Target: While the baseline is zero as this is a new program at the hospital, it is expected that 25% of the 1,608 eligible expected to be in the program or 402 patients will have controlled blood pressure. Therefore, in DY4, the goal is to increase the number of target patients in the program with controlled blood pressure by 1.5% and an additional improvement in DY5 of 1.5% over DY4.

IT-1.10 Diabetes care: HbA1c poor control (>9.0%). Improvement Target: While the baseline is zero as this is a new program at the hospital, it expected that 65% of the target population or 1,045 patients will have uncontrolled A1c level. Therefore, in DY4, the goal is to decrease the number of target patients in the program with uncontrolled A1c levelsby 1.5% with an additional decrease of 1.5% over DY4 in DY5.

IT-3.3 Diabetes 30 day readmission rate. Improvement Target: The target population in DY4 for this program is expected to be 1,608 patients. Historically, the diabetes readmission rate is 8.95%. Therefore, we expect the diabetes 30-day readmission rate among this target population to be 3.01% or 48 patients. In DY4, the goal is to decrease diabetes 30-day readmissions to the hospital from this target population by 10% with an additional 10% reduction over DY4 in DY5.

These outcomes support the project's purpose because if we do a better job of keeping people's blood pressure and HbA1C levels within appropriate limits, it will lower readmissions and the cost associated with managing chronic conditions of our patients.

Project Description

This project will apply evidence-based care management models for ED patients identified as having high-risk health care needs associated with diabetes. The project will develop chronic disease management education, protocols and self-management criteria for patients through a multi-disciplinary process. These protocols, once developed will be implemented in the hospital through new outpatient and inpatient education services, through the network of primary care physicians and made available to community clinics supporting diabetic patients. Historically, patients that do not effectively manage their diabetes tend to develop chronic diabetes complications, co-morbidities and lead to higher utilization and costs related to health care

services. This program will be implemented to help those who need education on managing diabetes and providing monitoring services where they are being treated. Patients will be identified by partnering with primary care physicians, community clinics and inpatient nurse/care managers. Patients identified as having high risk needs associated with diabetes will be based on clinical protocols of A1C>9, at least one ED visit in the past 12 months and/or have not received diabetes education within the past five years.

Goals and Relationship to Regional Goals

The goal of this project is to develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. The purpose for implementing a chronic disease management program for diabetes is based on hospital and community data. Diabetes related diagnoses account for the third highest patient segment for readmissions to the hospital. Diabetes management is also one of the top five community health needs with over 10% of the Dallas county population having been diagnosed with diabetes. The development and implementation of chronic disease management interventions for diabetes will lower costs and improve outcomes for the diabetic patients and community health status.

A major goal of the region is to improve the rate of chronic disease self-management and education. This project will contribute to that goal by providing patient education resources based on clinical management protocols.

Challenges

Hospital and market data indicates that approximately 40% of ED outpatient visits and 30% of inpatients with diabetes are Medicaid and uninsured patients. In the northern portion of the hospital service area 31% of the population is Hispanic and represents the fastest growing population segment. Hispanics are 1.5 times as likely to develop diabetes as non-Hispanic populations according to the CDC. Effective communication and creativity in reaching this community demographic has been identified as a challenge for this project.

5-Year Expected Outcome for Provider and Patients

- Formed multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar
- Developed a comprehensive diabetes care management program
- Developed and implemented plan for standing orders for diabetes patients
- Trained staff in the Chronic Care Model, including essential components of a delivery system that supports high-quality clinical and chronic diabetes management, and on the standing orders for diabetes patients

- Developed and implemented OP Diabetes Education Clinic and IP Educator program to assist patients to better self-manage their chronic diabetes
- Improved number of patients with self-management goals
- Improved number of patients being treated under the Chronic Care Model and/or Standing Orders for Diabetes

Starting Point/Baseline

Diabetes related diagnoses account for the third highest patient segment for readmissions to the hospital. Diabetes management is also one of the top five community health needs with over 10% of the Tarrant county population having been diagnosed with diabetes. The hospital currently does not offer outpatient diabetes education clinic services nor inpatient diabetes education. During DY2 and DY3 as the chronic health management program and clinical protocols for standing orders are developed, target populations will begin to be identifified. Historically, the ED has seen approximately 5,360 patients that also have a principal or secondary diagnosis of diabetes. We expect to target 30% of those with the program; 25% (or 402) are expected to have controlled blood pressure and 65% (or 1,045) uncontrolled A1c levels >9.0%.

Rationale

Promoting effective change in provider settings to support evidence-based clinical and quality improvement across a wide variety of health care settings will make a significant improvement to the self-management of chronic conditions such as diabetes. CDC data indicates that almost half of all Americans, more than 145 million, live with a chronic condition. In the hospital market more than 10% of the population has been diagnosed with diabetes and the number is growing. More than half of individuals with a chronic condition have multiple conditions. The challenge in the community due to the lack of proper self-management of chronic conditions is higher rates of illness, higher utilization of high cost services and lower quality of life.

Project Components

The following core project components were selected because they are sequential steps necessary to implement the project and each is designed to apply evidence-based care management model to patients identified as having high-risk health care needs related to diabetes.

a. We will design and implement multi-disciplinary teams that are tailored to the patient's health care needs to include clinical nursing, physician representation as well as members from finance, patient education and existing employee medical home leadership.

b. Patients enrolled into the program will receive contact information from patient navigators to ensure that patients can access their care teams in person, phone or email

c. An integral part of this project is to provide patient education and self-management support. We will incorporate learnings from the hospital's current medical home and ACO initiatives to improve 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. We will conduct ongoing quality improvement efforts for the project. The hospital's quality committee of the board meets regularly to assess ongoing programs at the facility and will be used to evaluate the success and improvement opportunities of the chronic care management project as well.

An integral part of this project is to provide patient education and self-management support. We will incorporate learnings from the hospital's current medical home and ACO initiatives to improve patient provider communication techniques and coordination with community resources.

We will conduct ongoing quality improvement efforts for the project. The hospital's quality committee of the board meets regularly to assess ongoing programs at the facility and will be used to evaluate the success and improvement opportunities of the chronic care management project as well.

Currently we use the Plan Do Check Act version of quality improvement for all of our programs at the hospital. We incorporate this process into any new program we do so that we embark with proper planning and have the systems in place to identify improvement opportunities throughout all stages of implementation.

Unique Community Need Identification Numbers the Project Addresses

- CN.13 Necessity of patient education programs
- CN.15 Need for more information to promote healthy lifestyles
- CN.11 Need for more care coordination

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

This project is a new initiative because the hospital does not have standing orders for diabetes protocols, does not offer dedicated diabetes education on self-management and has not received any other federal funding for it.

Related Category 3 Outcome Measure(s)

OD: Primary Care and Chronic Disease Management

- IT-1.10: Diabetes Care: HbA1c poor control (>9.0%)
- IT-1.11: Diabetes Control: Blood pressure control (<140/80mm Hg)

OD-3: Potentially Preventable Readmissions

- IT-3.3: Diabetes 30-day Readmissions rate

There are three Related Category 3 Outcome Measures for this project. The first two fall within Outcome Measure "Primary Care and Chronic Disease Management" (OD-1). Specifically the two Improvement Targets are IT-1.10 (Diabetes Care: HbA1c poor control (>9.0%)) and IT-1.11 (Diabetes Control: Blood pressure control (<140/80mm Hg)). This project will identify patients in the ED who are identified as having poor diabetes control. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market ultimately leading to better diabetes control outcomes.

The third Related Category 3 Outcome Measure falls within the Outcome Measure "Potentially Preventable Re-Admissions – 30-Day Readmission Rates" and is IT-3.3 Diabetes 30 day readmission rate. This project will identify ED patients who have poor diabetes control and ultimately at high risk for readmission to the hospital. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market. Better preparing patients for self-management, education and ongoing support for diabetes care will ultimately lead to reduced diabetic re-admissions from this target population.

Our process milestones measure the development of chronic care management program for diabetes, training and education of care givers in multiple care sites, development of standing orders for diabetic patients and the development of a new Outpatient Diabetes Education service and new Inpatient Educator program. The Improvement milestones measure the number of individuals that will targeted for the education and self-management protocols, as well as the increased number of patients with self-management goals. The specific improvement targets for the number of patients provided services for education and the number of patients with self-management goals will be determined during DY2.

Relationship to Other Projects

Related projects regarding chronic care management include:

- 126679303.2.1: Methodist Charlton Medical Center
- 135032405.2.2: Methodist Dallas Medical Center

This project will support, reinforce and enable the following Category 4, Reporting Domains through the project design and intervention for appropriate targeted patients:

- RD-1.2 (Preventable Admissions)-Diabetes Admission Rate
- RD-2.2 (Preventable 30 Day Re-Admissions)-Diabetes Re-Admission Rate
- RD-4.2 (Patient Centered Healthcare)-Medication Management

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

The RHP 9 projects regarding chronic care management are as follows:

Performing Provider	Unique Project	Project Option
Baylor University Medical Center	139485012.2.2	Expand Chronic Care Management Model – Diabetes (HbA1c poor control, BP control, foot exam)
Baylor Medical Center at Garland	121790303.2.2	
Baylor Medical Center at Irving	121776204.2.2	
Trinity Medical Center (Baylor-Carrollton)	195018001.2.1	
Children's Medical Center	138910807.1.3	Implement pediatric disease registry – asthma
Denton County HHS	13660803.2.1	Implement disease registry – diabetes
Methodist Charlton Medical Center	126679303.2.1	Expand Chronic Care Management Model – Diabetes (30-day readmission, Hba1c, BP control)
Methodist Dallas Medical Center	135032405.2.1	
Methodist Richardson Medical Center	209345201.2.1	
Parkland Health & Hospital System	127295703.1.3	Implement chronic care registry (Diabetes – retinal eye exam, 30-day readmissions)
Parkland Health &Hospital System	127295703.2.4	Expand Chronic Care Management Model – Diabetes (retinal eye exam; 30-day readmissions)
Texas Health Presbyterian Hospital Denton	020967801.2.2	Expand Chronic Care Management Model: Diabetes (HbA1c poor control, 30 day readmissions)
Texas Health Presbyterian Hospital Kaufman	094140302.2.2	
UTSW – Faculty Practice Plan	126686802.2.2	Expand Chronic Care Management Model (Diabetes: HbA1c control; All Cause Readmissions)

Plan for Learning Collaborative: We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the

program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

135032405.2.2	*2.2.2*	*NA*	*Title: Expand Chronic Care Management Model for Diabetes*	
Methodist Dallas Medical Center				*135032405*
Related Category 3 Outcome Measures :	*135032405.3.3* *135032405.3.4* *135032405.3.5*	*IT-1.10* *IT-1.11* *IT-3.3*	*Diabetes Care: HbA1c poor control* *Diabetes Care: Blood Pressure control* *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-4] Formalize multi-disciplinary teams, pursuant to the chronic care model defined by Wagner Chronic Care Model. Metric 1 [P-4.1]: Increase the number of multi-disciplinary teams Baseline = 0/Goal = 1 Data Source: Administrative records Milestone 1 Estimated Incentive Payment (max amount): $895,294 **Milestone 2** [P-3] Develop a comprehensive care management program Metric 1 [P-3.1]: Baseline = 0 /Goal: care management document Data Source: Administrative records Milestone 2 Estimated Incentive Payment (max amount): $895,294	**Milestone 3** [P-12] Develop and implement plan for standing orders Metric 1 [P-12.1] Documentation of plan for standing orders Baseline = 0 /Goal: care management document Data Source: Administrative records Milestone 3 Estimated Incentive Payment (max amount): $651,145 **Milestone 4** [P-2] Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 [P-2.1] Increase percent of staff trained Baseline = 0% /Goal: 5% Data Source: Administrative records Milestone 4 Estimated Incentive Payment (max amount): $651,145 **Milestone5** [P-11]	**Milestone 6** [I-17] Apply the Chronic Care Model to targeted chronic diseases which are prevalent locally, such as diabetes Metric 1 [I-17.1]: Percent of diabetic ED patients receiving care under the Chronic Care model Baseline/Goal: 10/ 1,608 Data Source: Administrative records Milestone 6 Estimated Incentive Payment (max amount): $979,558 **Milestone 7** [I-18]: Improve the percentage of diabetic ED patients with self-management goals Metric 1 [I-18.1]: Diabetic ED patients with self-management goals Baseline/Goal: 0 / 80 Data Source: Administrative records Milestone 7 Estimated Incentive Payment (max amount): $979,557	**Milestone 8** [I-17] Apply the Chronic Care Model to targeted chronic diseases which are prevalent locally, such as diabetes Metric 1 [I-17.1] Percent of diabetic ED patients receiving care under the Chronic Care model Baseline/Goal: 1,608 /increase of 5% over DY4. Data Source: Administrative records Milestone 8 Estimated Incentive Payment (max amount): $809,200 **Milestone 9** [I-18] Improve the percentage of diabetic ED patients with self-management goals Metric 1 [I-18.1] Diabetic ED patients with self-management goals Baseline/Goal: 80 / 160Data Source: Administrative records Milestone 9 Estimated Incentive Payment (max amount): $809,200

135032405.2.2	*2.2.2*	*NA*	*Title: Expand Chronic Care Management Model for Diabetes*	
Methodist Dallas Medical Center				*135032405*
Related Category 3 Outcome Measures :	*135032405.3.3* *135032405.3.4* *135032405.3.5*	*IT-1.10* *IT-1.11* *IT-3.3*	*Diabetes Care: HbA1c poor control* *Diabetes Care: Blood Pressure control* *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)**
	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 Baseline = 0 /Goal: 10 by 9/30/2014 Data Source: Administrative records Milestone 5 Estimated Incentive Payment (max amount): $651,146		
Year 2 Estimated Milestone Bundle Amount (add incentive payment amounts from each milestone): $1,790,588	**Year 3 Estimated Milestone Bundle Amount:** $1,953,436	**Year 4 Estimated Milestone Bundle Amount:** $1,959,115	**Year 5 Estimated Milestone Bundle Amount:** $1,618,400
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):			**$7,321,539**

Project Option 2.1.1 – Enhance/Expand Medical Homes

Unique Project ID: 135032405.2.3

Performing Provider Name/TPI: Methodist Dallas Medical Center/135032405

Provider: Methodist Dallas Medical Center is a 515-bed facility in southern Dallas County serving a 537 square mile area and a population of approximately 1,019,000. Methodist Dallas Medical Center is a designated safety net hospital and the only Level 2 trauma center located in its service area, providing a full range of acute care services to broad range of patients with all types of injuries and diseases across the continuum of care. In the last year, forty-five percent of Methodist Dallas' patients were Medicaid eligible or uninsured representing $327 million in charges for those services.

Intervention: The purpose of "The Medical Home" project is to expand and improve a community-based, multi-stakeholder, health care access program increasing the capacity to care for more uninsured Dallas County residents while demonstrating accountability for improved health outcomes.

Key functional elements of "The Medical Home" project include:

- A network of certified patient centered medical homes (e.g. NCQA) for primary care access.
- A narrow network of specialty care physicians for efficient specialty care access.
- A network of community hospitals committed to efficient post-acute care transitions.
- Community Care Transitions staff facilitating effective and efficient post-acute care PCMH connections.
- Community Care Nurse Case Management staff facilitating chronic disease care plans and home-based care (where necessary).
- A network of outpatient ancillary radiology, lab and pharmaceutical services.
- A Health IT system facilitating patient enrollment, referrals, transitional care, case management, risk stratification, chronic disease registries, population management and utilization efficiency reporting.
- A Quality Improvement Plan to help achieve improved outcomes.

The Medical Home project (1) expands/increases the number of patients accessing care at a medical home, (2) through the health information exchange, links clinical data sharing between performing providers, physicians and community/charity clinics and (3) establishes a quality improvement committee to look at clinical outcomes.

Need for Project: The regional need is to provide improved access to coordinated primary and specialty care. This project would contribute to achieving that goal by implementing a

collaborative across multiple performing providers committed to identifying eligible uninsured residents access to a patient centered medical home. The project is multi-stakeholder regional approach to address access to care for eligible low income Dallas County residents.

Target Population: The target population is our patients are assigned to a "home" with a health care team who provides services based on a patient's unique health needs, effectively coordinates the patient's care across inpatient and outpatient settings and proactively provides preventive, primary, routine and chronic care.

Approximately 45% of our patients are either Medicaid eligible or indigent so we expect about 45% of the patients enrolled in the program to be Medicaid eligible or indigent.

Category 1 or 2 Expected Patient Benefits:

I-12: Based on criteria, improve the number of eligible patients that are assigned to the medical homes. The project seeks to increase the number of eligible patients assigned to medical home by 10% over baseline in DY4 and additional improvement of 10% over DY4 in DY5.

I-13 New patients assigned to a medical home receive their first appointment in a timely manner. The project will improved the percent of new patients assigned to medical home for their first visit in 60-120 days by 10% over baseline in DY4 and additional improvement of 15% over DY4 in DY5.

Category 3 Outcome selected: IT-11.5 All cause admission rate for Chronically-ill patients as defined by performing provider. In DY4, achieve an admission rate approximately 10% lower than baseline for patients enrolled at least one year in the Medical Home project and 15% lower in DY5.

Project Description

Dallas County's public hospital is at, or has exceeded, its currently available primary and specialty care capacity. Community hospitals and private physicians are limited in their ability to meet the need, based on current reimbursement/financing mechanisms. To address this challenge, Methodist Dallas Medical Center will support two charitable clinics in their efforts to expand or enhance the delivery of care provided through the Patient Centered Medical Home (PCMH) model. This plan builds upon existing resources/relationships and focuses on transforming two (Grand Prairie Wellness Center and Brother Bills Dallas Clinic) community/charity clinics to patient centered medical homes. The PCMH provides a primary care "home" for the patients. Patients are assigned to a "home" with a health care team who provides services based on a patient's unique health needs, effectively coordinates the patient's care across inpatient and outpatient settings and proactively provides preventive, primary, routine and chronic care. Also, the plan creates financial incentives and opportunities for community hospitals, private physicians and community/charity clinics to provide care to a "cohort" of uninsured/underinsured residents in performing provider service area.

Key components of The Medical Home project are:

Clinics and Primary Care Physicians
MEDICAL HOME clinics and primary care physicians serve as the medical home for MEDICAL HOME patients. The principle role is to provide a single point of accessible, continuous, comprehensive and coordinated medical care which includes specialists, hospital and post-acute care.

Specialty Care Physicians
MEDICAL HOME specialty care physicians provide specialty and sub-specialty care for MEDICAL HOME patients. The principle role is to have an identified network to schedule specialty appointments in a timely manner based on patient need.

Community Care Transitions
MEDICAL HOME staff performing community care transitions are community health workers supported by a nurse or social worker manager from a participating community hospital. Their principle role is respond to patient referrals to facilitate efficient hospital discharge and post-acute care connection to a primary care clinic or physician.

Community Health Navigation & Transportation
MEDICAL HOME staff performing health navigation and transportation services are community health workers who respond to requests from primary care clinics and physicians on behalf of high-risk patients. The principle role is to develop care coordination plans with patients and families to reduce medical and social complications leading to adherence and compliance barriers.

Community Pharmacy Navigation
MEDICAL HOME staff performing pharmaceutical navigation are community health workers dedicated to facilitating the continuous access to prescribed medications for low-income, uninsured chronically ill patients. The principle role is to assist MEDICAL HOME patients taking chronic disease management medications access affordable generic and brand named products from pharmaceutical company patient assistance programs. This role compliments the MEDICAL HOME pharmaceutical benefit available through PAD's Pharmaceutical Benefits Manager.

Community Specialty Referral Management
MEDICAL HOME staff performing specialty physician care referral management are dedicated to connecting MEDICAL HOME patients and their health information to MEDICAL HOME's specialty care network, upon referral from a primary care provider. The principle role is to reduce the number of days between the primary care physician's decision for a specialty care consultation and the patient's actual specialty care physician visit.

Community Nurse Case Management & House Calls

MEDICAL HOME staff performing case management and house calls are registered nurses and/or advance practice nurses dedicated to helping primary care clinics and physicians provide chronic disease management to complex MEDICAL HOME patients. It is estimated that 5-10% of the MEDICAL HOME population will require Case Management services (and house call when necessary). This service enables MEDICAL HOME to accept the sickest, most challenging patients from participating hospitals.

Project Goals

The purpose of the "The Medical Home" project is to expand and improve a community-based, multi-stakeholder, health care access program increasing the capacity to care for more uninsured Dallas County residents while demonstrating accountability for improved health outcomes. Key functional elements of MEDICAL HOME include:

- A network of certified patient centered medical homes (e.g. NCQA) for primary care access.
- A narrow network of specialty care physicians for efficient specialty care access.
- A network of community hospitals committed to efficient post-acute care transitions.
- Community Care Transitions staff facilitating effective and efficient post-acute care PCMH connections.
- Community Care Nurse Case Management staff facilitating chronic disease care plans and home-based care (where necessary).
- A network of outpatient ancillary radiology, lab and pharmaceutical services.
- A Health IT system facilitating patient enrollment, referrals, transitional care, case management, risk stratification, chronic disease registries, population management and utilization efficiency reporting.
- A Quality Improvement Plan to help achieve improved outcomes.

The goals of the "The Medical Home" project are:

- Expand or enhance the delivery of care provided through the Patient-Centered Medical Home (PCMH) model.
- Develop incentives focused on quality capable of supporting physicians and clinics for expanding access, beyond their base volunteerism, increasing the number of uninsured working poor with meaningful connections to medical homes, specialty physician care and hospital-based health care services.

- Develop meaningful digital health information collection and exchange between providers of care, to reduce the total medical cost of care while increasing the quality of care for the uninsured working poor.
- Develop actionable health information analytical capability for reporting provider network performance, patient risk stratification and population management, leverage the intellectual property of providers in achieving qualitative and quantitative improvement in care for the uninsured working poor.

Challenges/Issues

Community hospitals and private physicians are limited in their ability to meet the needs of the growing number of the uninsured population. This project aims to expand access to this population by creating more patient centered medical homes which will increase efficiency and reduce the cost of providing care to this population. Options for the uninsured to access coordinated and comprehensive health care are limited. This project was specifically selected because the community has a ten year history of working together to address these needs of eligible uninsured residents in Dallas County. The project aims to provide patients with additional high quality services that are accountable and measurable and improve their care and health care experience.

5 Year Expected Outcomes

The expected outcomes of the "The Medical Home" project are to provide the following for a "cohort" of uninsured/underinsured Dallas County residents:

<u>Core Outcomes</u>

- Establish medical home assignment criteria
- Identify evidence based training materials for medical homes based on model change concepts
- Identify and increase in the number of Dallas residents obtaining primary care medical homes (DYs 2-5 aggregate impact 6600 unduplicated patients)
- Identify and improve the number/percent of new patients that receive their first appointment in a timely manner

<u>Optional Outcome</u>

- Identify and increase in the number of Dallas community clinics achieving patient centered medical home certification from a nationally recognized agency

<u>How is project related to other regional goals</u>

A major goal of the region is to provide improved access to coordinated primary and specialty care. This project would contribute to achieving that goal by implementing a collaborative across multiple performing providers committed to identifying eligible uninsured residents

access to a patient centered medical home. The project is multi-stakeholder regional approach to address access to care for eligible low income Dallas County residents.

Starting Baseline

Community stakeholders including hospitals, physicians and community/charity clinics have worked together for the past decade to identify and provide access to coordinated primary and specialty care for the uninsured. With a baseline of two community/charity clinics, the project has served an aggregate of 410 unduplicated patients of all performing providers between January 1 and September 31, 2012. Based on that experience, we plan to increase the number of eligible patients assigned to a medical home via The Medical Home project by at least 10% annually.

Rationale

As indicated in the Dallas Fort Worth Hospital Council's RHP 9 Community Needs Assessment, there is a strong demand for primary and specialty care services. The demand for hospital, primary care and specialty care services exceeds the supply of available medical physicians in the hospital's service area, thus limiting health care access for many low level management or specialized treatment for prevalent health conditions. Many primary care physicians accept a limited number of the Medicaid/Uninsured population due to the lack of coordination of care and access to appropriate ancillary services. Consequently, many residents seek primary care treatment in emergency care settings resulting in increased healthcare costs and higher volumes of preventable and avoidable cases populating emergency department waiting rooms. Thus, improved/continued support to physicians, community/charity clinics and hospitals through the exchange of information, coordination of services with interconnected health systems, physicians and community/charitable clinics and the implementation of innovative approaches can have a significant impact on the uninsured ability to access care and improve outcomes. We have selected this project to enhance the role of the of community/charity clinics by creating more patient centered medical care home options in the region. The key project components will be addressed

Core Components

Our project includes the following components to develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.

Required core project components:

- Utilize a gap analysis to assess community/charity clinics' NCQA PCMH readiness.
- Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status
- Conduct educational sessions for community/charity clinic's boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision.
- 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.

Reason for selecting milestones/metrics

Our milestones measure an increased population receiving care through a PCMH model of care: (1) we are establishing and implementing medical home assignment criteria, (2) we are utilizing evidence based training materials for medical homes based upon model change concepts, (3) we are increasing the number of eligible patients assigned to a medical home, (4) we are increasing the number of new patients assigned to medical homes that are contacted for medical visit within 60 – 120 days and (5) we are documenting medical home recognition/accreditation of community/charity clinic by a nationally recognized agency (e.g. NCQA).

Community Needs Assessment Identification Number

- CN.3 Healthcare Capacity
- CN.8 Chronic Disease

Describe how the project represents a new initiative or significantly enhances an existing delivery system reform initiative

This project enhances an existing regional program Project Access Dallas. The Medical Home project (1) expands/increases the number of patients accessing care at a medical home, (2) through the health information exchange, links clinical data sharing between performing providers, physicians and community/charity clinics and (3) establishes a quality improvement committee to look at clinical outcomes.

Related Category 3 Outcome Measures

The impact of the proposed The Medical Home project can be measured by one standalone Category 3 Outcome Measure. 1) IT- 11.5 All-Cause Admission Rate for Chronically-Ill patients. This measure is will demonstrate the importance of assigning low income uninsured residents to a medical home. By doing so, this will decrease the admission rate for chronically ill (diagnosis of Diabetes, CHF, Hypertension, COPD, or Asthma) MEDICAL HOME patients post enrollment.

Relationship to other Projects

To be completed by performing provider and/or anchor

Plan for Learning Collaborative: We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9

and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

135032405.2.3	*2.1.1*	*2.1.1 (A-D)*	*THE MEDICAL HOME PROJECT*
Methodist Dallas Medical Center			*135032405*
Related Category 3 Outcome Measure(s)	*135032405.3.6*	*3.IT-11.5*	*Addressing Health Disparities in Minority Populations: All-Cause Admission Rate for Chronically-Ill patients- as defined by performing provider*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-6] Establish/ implement criteria for medical home assignment **Metric 1: P-6.1:** Medical home assignment criteria Baseline: 0 / Goal: Criteria established Data source: Administrative records Milestone 1 Estimated Incentive Payment (max amount): $169,265 **Milestone 2 [P-7]** Track the assignment of patients to the dedicated care team. **Metric 2: P-8.1:** Documentation of training materials Baseline: 410 / Goal: 451 Data Source: Administrative records Milestone 2 Estimated Incentive Payment (max amount): $169,265 **Milestone 3 [I-12]** Based on criteria, improve the number of eligible patients that are assigned to the medical homes. **Metric 3: I-12.1:** Establish baseline	**Milestone 5 [P-8]:** Develop or utilize evidence based training material for medical homes based upon model change concepts **Metric 5: P-8.1:** Documentation of training materials Baseline: 0 / Goal: Training materials developed Data Source: Administrative records Milestone 5 Estimated Incentive Payment (max amount): $230,765 **Milestone 6: [I-12]:** Based on criteria, improve the number of eligible patients that are assigned to the medical homes. **Metric 6: [I-12.1]:** Increase the percent of eligible patients assigned to medical homes, where "eligible" by 10%. Baseline: 451 / Goal: 492 Data Source: Administrative records Milestone 6 Estimated Incentive	**Milestone 8 [I-12]:** Based on criteria, improve the number of eligible patients that are assigned to the medical homes. **Metric 8: I-12.1:** Increase the percent of eligible patients assigned to medical homes, where "eligible" by 10%. Baseline: 492 / Goal: 545 Data Source: Administrative Milestone 8 Estimated Incentive Payment (max amount): $356,690 **Milestone 9 [I-13]:** New patients assigned to a medical home receive their first appointment in a timely manner **Metric 9: I-13.1:** Improve percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days over baseline by 10%. Baseline: 100 days / Goal: 80 days Data Source: Administrative records	**Milestone 10 [I-12]:** Based on criteria, improve the number of eligible patients that are assigned to the medical homes. **Metric 10: I-12.1:** Increase the percent of eligible patients assigned to medical homes, where "eligible" by 10%. Baseline: 545 / Goal: 600 Data Source: Administrative records Milestone 10 Estimated Incentive Payment (max amount): $306,335 **Milestone 11 [I-13]:** New patients assigned to a medical home receive their first appointment in a timely manner **Metric 11: I-13.1:** Improve percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days over baseline by 15%. Baseline: 80 days / Goal: 60 days Data Source: Administrative records

135032405.2.3	*2.1.1*	*2.1.1 (A-D)*	*THE MEDICAL HOME PROJECT*	
Methodist Dallas Medical Center				*135032405*
Related Category 3 Outcome Measure(s)	*135032405.3.6*	*3.IT-11.5*	*Addressing Health Disparities in Minority Populations: All-Cause Admission Rate for Chronically-Ill patients- as defined by performing provider*	

Year 2 (10/1/2012 – 9/30/2013)	**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 the number of eligible patients assigned to medical homes, where "eligible" is defined by the performing provider. Baseline: 410 / Goal: 451 Data Source: Administrative records Milestone 3 Estimated Incentive Payment (max amount): $169,265 **Milestone 4 [I-13]:** New patients assigned to a medical home receive their first appointment in a timely manner **Metric 4: I-13.1:** Establish percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days Baseline: 140 days / Goal: 120 daysData Source: Administrative records Milestone 4 Estimated Incentive Payment (max amount): $169,264	Payment (max amount): $230,765 **Milestone 7 [I-13]:** New patients assigned to a medical home receive their first appointment in a timely manner **Metric 7: I-13.1:** Improve the number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days Baseline: 120 days / Goal: 100 days Data Source: Administrative records Milestone 7 Estimated Incentive Payment (max amount): $230,766	Milestone 9 Estimated Incentive Payment (max amount): $356,691	Milestone 11 Estimated Incentive Payment (max amount): $306,335

135032405.2.3	***2.1.1***	***2.1.1 (A-D)***	***THE MEDICAL HOME PROJECT***
Methodist Dallas Medical Center			*135032405*
Related Category 3 Outcome Measure(s)	*135032405.3.6*	*3.IT-11.5*	*Addressing Health Disparities in Minority Populations: All-Cause Admission Rate for Chronically-Ill patients- as defined by performing provider*

Year 2 (10/1/2012 – 9/30/2013)	**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): $677,059	Year 3 Estimated Milestone Bundle Amount: $692,296	Year 4 Estimated Milestone Bundle Amount: $713,381	Year 5 Estimated Milestone Bundle Amount: $612,670
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $2,695,406			

2.9.1 Establish/Expand a Patient Care Navigation Program

Unique Project ID: 209345201.2.1
Performing Provider Name/TPI: Methodist Richardson Medical Center/209345201

Summary

Provider: Methodist Richardson Medical Center is a 209-bed facility in northern Dallas County serving a 245 square mile area and a population of approximately 740,000.
Methodist Richardson Medical Center provides a full range of acute care services to broad range of patients with all types of injuries and diseases across the continuum of care. Other than transplants, all other medical specialties are represented at this facility. In the last year, nearly twenty-six percent of Methodist Richardson's patients were Medicaid eligible or uninsured representing $49 million in charges for those services.

Intervention: To provide patient navigation services in the Emergency Room to patients who are at high risk of disconnecting from institutionalized health care services or are identified as not having a primary care physician and/or medical home to address their needs. This project will identify frequent ED users and use navigators as part of a preventable ED reduction program. This project will connect patients to primary and preventative care and increase access to care management and/or chronic care management which should improve unnecessary ED utilization as well as the health condition of those most at risk for costly chronic conditions.

This project is a new initiative because the hospital does not provide patient navigation services in the ED currently and has not received any other federal funding for it.

Need for the Project: A major goal of the region is to reduce the unnecessary utilization in the Emergency Departments of the DFW hospitals. This project will contribute to that goal by providing patient navigation resources that would identify patients that are eligible to receive care in a more appropriate setting. This project will impact a specific portion of the population in the region as well as provide a knowledge base that could be applied to other regional hospitals.

Target Population: The target population is frequent users of the emergency department, defined as six or more visits per year, estimated to be 4.3% of total ED visits, or 1,445 patients per year.
Approximately 43% of our ED patients are either Medicaid eligible or indigent so we expect about 43% of the patients helped by the program to be Medicaid eligible or indigent.

Category 1 & 2 Expected Patient Benefit: I-6 Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services. Improvement Target: Baseline will be established in DY3, which is expected to be 1,445 targeted patients

identified as frequent users of ED services. The project seeks to refer at least 50% of this target population or 723 to a more appropriate primary care setting for follow up care in DY 4 and 70% of the original baseline referred to primary care in DY5.
I-8 Reduction in ED use by identified ED frequent users receiving navigation. Improvement Target: Baseline will be established in DY3 which is expected to be 723. The project seeks to realize a 2.5% reduction over baseline expected in DY4 and an additional improvement of 2.5% of the prior year in DY5.

Category 3 Outcome: IT-9.2 Appropriate ED Utilization. Improvement Target: Baseline will be established in DY3. Decrease utilization of ED patients from baseline by 2.0% in DY4 and an additional reduction of 2.0% over prior year in DY5.

IT-3.1 All cause 30 day readmission rate. Improvement Target: Baseline will be established in DY3. Decrease readmissions to the hospital from baseline by 1.5% in DY4 and an additional reduction of 3.0% over prior year in DY5.

These improvement milestones and outcomes support the project's objective to reduce utilization of high cost ED settings by placing frequent users of the emergency department into a more appropriate care setting.

Project Description

This project will provide patient navigation services in the Emergency Room to targeted patients who are at high risk of disconnecting from institutionalized health care services or are identified as not having a primary care physician and/or medical home to address their needs. This project will identify frequent ED users and use navigators as part of a preventable ED reduction program. This project will increase the number of people trained and deployed for innovative health services such as social workers. This project will connect patients to primary and preventative care and increase access to care management and/or chronic care management. This project should improve the utilization of unnecessary ED utilization as well as improve the health condition of those most at risk for costly chronic conditions.

Goals and Relationship to Regional Goals

The goal of this project is to utilize community health workers, case managers or other types of healthcare professionals as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient navigators will help and support these patients to navigate through the continuum of care services. Patient Navigators will ensure that patients receive timely, coordinated and site appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the ED to site-appropriate locations. Implementing this project will identify health care workers, case managers or other types of health professionals needed to engage with patients in a culturally and linguistically

appropriate manner that will be essential to guiding the patients through the integrated health care delivery systems.
A major goal of the region is to reduce the unnecessary utilization in the Emergency Departments of the DFW hospitals. This project will contribute to that goal by providing patient navigation resources that would identify patients that are eligible to receive care in a more appropriate setting. This project will impact a specific portion of the population in the region as well as provide a knowledge base that could be applied to other regional hospitals.

Challenges

Emergency Departments have become a vital source of care for those without insurance who generally lack a source of primary care, since they are required to evaluate and treat patients regardless of the ability to provide payment. Consequently, although care delivered through the ED is frequently for non-urgent problems, it is substantially more costly than care delivered in a more appropriate setting. DFW and National data indicate that the 26% of non-elderly individuals that are without health insurance exceeds the nearly 19% nationally of non-elderly individuals are without health insurance. These rates increase for individuals with lower incomes. Minority and low-income individuals without insurance generally lack a regular source of medical care, and suffer from medical conditions that are either preventable or easily treated in the outpatient setting. Consequently, the uninsured are four times more likely than the insured to forgo or postpone needed preventative care. The ED has become a societal solution for those with chronic conditions and/or lacking access to primary care. The patient navigation project will be focused on overcoming these societal challenges. Additional challenges will include the acquisition of professional resources that have a background and training to provide social services and navigation care services, as well as overcoming the reliance on personal accountability of the patient to follow up with a provider in a more appropriate care setting.

5-Year Expected Outcome for Provider and Patients

The expected outcomes for the patient navigation project are to:

- Identified frequent ED users and use of navigators as part of preventable ED reduction program.
- Trained health care navigators in cultural competency.
- Deployed innovative health care personnel such as case managers/workers, community health workers and other types of health professionals as patient navigators.
- Connected patients to primary and preventative care.
- Increased access to care management and/or chronic care management, including education in chronic disease self-management.
- Decreased of inappropriate ED utilizations.

Starting Point/Baseline

Currently the baseline is zero. During DY2 frequent ED users will be identified based on a needs assessment to identify the patient population for which the program will be targeted. Patient navigation and care management will be provided to these patients. DY3 will serve as the baseline period for the project. Based on the number of patients served by the project, the number of providers trained to support the program will be identified and implemented.

Rationale

Emergency Department utilization in North Texas exceeds national utilization rates resulting in higher costs for providing care to the region. The Community Health Needs Assessment points to a lack of accessing primary care sites and the inability to redirect patients to a more appropriate care setting. The patient navigator project will provide resources to help patients and their families better locate and navigate appropriate care locations.

Project Components

The following core project components were selected because each component is designed to provide and improve navigation services to targeted patients who are at high risk of disconnect from institutionalized health care:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators

c) Connect patients to primary and preventative care

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management

e) We will conduct ongoing quality improvement efforts for the project. The hospital's quality committee of the board meets regularly to assess ongoing programs at the facility and will be used to evaluate the success and improvement opportunities of the chronic care management project as well.

Currently we use the Plan Do Check Act version of quality improvement for all of our programs at the hospital. We incorporate this process into any new program we do so that we embark with proper planning and have the systems in place to identify improvement opportunities throughout all stages of implementation.

Our milestones measure the reduction in the number of patients who frequently use the ED; 1) we are increasing the number of patients identified as frequent users of the ED; 2) increasing the number of patients referred to more appropriate care settings. As a result of these efforts, there will be a reduction in the number of ED visits by those enrolled in the program by 5% by DY5. These milestones will meaure whether we have increased the number of frequent ED users that are provided navigation services, increased the number of patient navigation resources, and as a result, decreased inappropriate ED utilization.

Unique Community Need Identification Numbers the Project Addresses

- CN.1: Demographics
- CN.2: Healthcare Infrastructure
- CN.8: Specialty Care
- CN.10: Oral Health
- CN.11: Patient Safety and Quality
- CN.13: Palliative Care

How the Project represents a new initiative

This project is a new initiative because the hospital does not provide patient navigation services in the ED currently and has not received any other federal funding for it.

Related Category 3 Outcome Measure(s)

There are two Related Category 3 Outcome Measures for this project. The first is Outcome Measure "Right Care, Right Setting" (OD-9) and IT-9.2 ED Utilization. Specifically there will be a reduction in all ED visits if the patient navigation program is effective. By identifying frequent users of the ED and providing navigation services, these patients will be exposed to alternative care locations that would be more effective for managing their non-urgent health conditions and health need. The IT-9.2 measures is the most appropriate indicator to assess the results of care experienced by patients, including patients' clinical events, patients' recovery and health status, patients' experiences in the health system, and efficiency/cost.

The second is Outcome Measure "Potentially Preventable Re-Admissions – 30 Day Readmission Rates" and IT-3.1 All cause 30 day readmission rate. The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the lack of chronic disease management and lack of access to appropriate sites of care. The patient navigator program will re-direct patients from the ED to a more appropriate care setting, where management of chronic conditions will be better suited. A reduction in frequent ED users and access to better care site for chronic conditions will lead to a reduction in readmission rates for those enrolled in the program.

Our milestones measure the reduction in the number of patients that frequently use the ED; 1) we are increasing the number of patients identified as frequent users of the ED, 2) increasing the number of patient navigators available to provide services to those patients, and 3) increasing the number of patients referred to more appropriate care settings. As a result of these efforts, there will be a reduction in the number of ED visits by 3%. These milestones will measure whether we have increased the number of frequent ED users that are provided navigation services, increased the number of patient navigation resources, and as a result, decreased inappropriate ED utilization.

Relationship to Other Projects

126679303.2.2 Methodist Charlton Medical Center
135032405.2.3 Methodist Dallas Medical Center

This project will support, reinforce and enable the following Category 4, Reporting Domains through the project design and intervention for appropriate targeted patients:

- RD-1.1 (Preventable Admissions)-CHF Admission Rate
- RD-1.2 (Preventable Admissions)-Diabetes Admission Rate
- RD-1.4 (Preventable Admissions)-COPD/Asthma Admission Rate
- RD-1.5 (Preventable Admissions)-Hypertension Admission Rate
- RD-2.1 (Preventable 30 Day Re-Admissions)-CHF Re-Admission Rate
- RD-2.2 (Preventable 30 Day Re-Admissions)-Diabetes Re-Admission Rate
- RD-2.4 (Preventable 30 Day Re-Admissions)-COPD/Asthma Re-Admission Rate
- RD-2.5 (Preventable 30 Day Re-Admissions)-Hypertentsion Re-Admission Rate

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative
The RHP 9 projects related to patient navigation are as follows:

Performing Provider	Unique Project
Baylor Medical Center at Garland	121790303.2.3
Baylor Medical Center at Irving	121776204.2.3
Baylor University Medical Center	139485012.2.3
Children's Medical Center	138910807.2.3
Medical Center of Lewisville (HCA)	094192402.2.3
Methodist Charlton Medical Center	126679303.2.2
Methodist Dallas Medical Center	135032405.2.1
Methodist Richardson Medical Center	209345201.2.1
Parkland Health & Hospital System	127295703.2.7
Texas Health Presbyterian – Denton	020967801.2.1
Texas Health Presbyterian – Kaufman	094140302.2.1
University of Texas Southwestern – Faculty	126686802.2.4
University of Texas Southwestern – Hospital	175287501.2.1

Plan for Learning Collaborative: We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

209345201.2.1	2.9.1	*2.9.1 (a-e)*	*Expand Patient Care Navigation Program*	
Methodist Richardson Medical Center				*209345201*
Related Category 3 Outcome Measures :	*209345201.3.1* *209345201.3.2*	*IT-3.1* *IT-9.2*	*All Cause Readmissions* *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] Establish 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 navigation education. Metric 1 [P-2.1]: Number of people trained as navigator Baseline = 0/Goal = 1 Data Source: Administrative records Milestone 1 Estimated Incentive Payment (max amount): $376,966 **Milestone 2** [P-3] Provide care management/ navigation services to targeted patients. Metric 1 [P-3.1]: Increase in number or percent of targeted patients enrolled Baseline = 0 /Goal: Start program to see first patient by 9/30/2013 Data Source: Administrative records Milestone 2 Estimated Incentive Payment (max amount): $376,965	**Milestone 3** [P-2] Establish 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 navigation education. Metric 1 [P-2.1]Number of people trained as patient navigator Baseline = 1/Goal = 2 Data Source: Administrative records Milestone 3 Estimated Incentive Payment (max amount): $411,250 **Milestone 4** [P-3] Provide care management/ navigation services to targeted patients. Metric 1 [P-3.1] Increase in number or percent of targeted patients enrolled Baseline = 1 /Goal: 723 Data Source: Administrative records Milestone 4 Estimated Incentive Payment (max amount): $411,249		**Milestone 5** [I-6] Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services. Metric 1 [I-6.3]: Percent of patients without a primary care provider who are referred to a primary care provider in ED Baseline: 0 /Goal: 50% of targeted patients in the program or 362 Data Source: Administrative records Milestone 5 Estimated Incentive Payment (max amount): $412,445 **Milestone 6** [I-8] Reduction in ED use by identified frequent users receiving navigation services. Metric 1 [I-8.1]: ED visits pre- & post-navigation services by individuals identified as ED frequent users Baseline: 1,455 /Goal: / 2.5% reduction from baseline. Data Source: Administrative records	**Milestone 7** [I-6] Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services. Metric 1 [I-6.3]Percent of patients without a primary care provider who are referred to a primary care provider in the ED Baseline/Goal: 362/70% of original baseline or 506. Data Source: Administrative records Milestone 7 Estimated Incentive Payment (max amount): $340,716 **Milestone 8** [I-8] Reduction in ED use by identified ED frequent users receiving navigation services. Metric 1 [I-8.1]: ED visits pre- and post-navigation services by individuals identified as ED frequent users Baseline/Goal: 2.5 / 2.5% over prior year DY4. Data Source: Administrative records Milestone 8 Estimated Incentive

209345201.2.1	2.9.1	*2.9.1 (a-e)*	*Expand Patient Care Navigation Program*	
Methodist Richardson Medical Center				*209345201*
Related Category 3	*209345201.3.1*	*IT-3.1*	*All Cause Readmissions*	
Outcome Measures :	*209345201.3.2*	*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 6 Estimated Incentive Payment (max amount): $412,445	Payment (max amount): $340,715
Year 2 Estimated Milestone Bundle Amount: $753,931		**Year 3 Estimated Milestone Bundle Amount:** $822,499	**Year 4 Estimated Milestone Bundle Amount:** $824,890	**Year 5 Estimated Milestone Bundle Amount:** $681,431
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $3,082,751				

Project Option 2.2.1 - Expand Chronic Care Management Models

Unique Project ID: 209345201.2.2
Performing Provider Name/TPI: Methodist Richardson Medical Center/209345201

Provider: Methodist Richardson Medical Center is a 209-bed facility in northern Dallas County serving a 245 square mile area and a population of approximately 740,000.

Methodist Richardson Medical Center provides a full range of acute care services to broad range of patients with all types of injuries and diseases across the continuum of care. Other than transplants, all other medical specialties are represented at this facility. In the last year, nearly twenty-six percent of Methodist Richardson's patients were Medicaid eligible or uninsured representing $49 million in charges for those services.

Intervention: The primary purpose of this project is to develop and implement a chronic disease management intervention geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization.
This project is a new initiative because the hospital does not have standing orders for diabetes protocols, does not offer dedicated diabetes education on self-management and has not received any other federal funding for it.

Need for the Project: Promoting effective change in provider settings to support evidence-based clinical and quality improvement across a wide variety of health care settings will make a significant improvement to the self-management of chronic conditions such as diabetes. CDC data indicates that almost half of all Americans, more than 145 million, live with a chronic condition. In the hospital market more than 10% of the population has been diagnosed with diabetes and the number is growing.
More than half of individuals with a chronic condition have multiple conditions. The challenge in the community due to the lack of proper self-management of chronic conditions is higher rates of illness, higher utilization of high cost services and lower quality of life.

Target Population: The target population is our ED patients that have either a principal or secondary diagnosis of diabetes and need education on managing diabetes and have high risk needs associated with diabetes based on clinical protocols of HbA1c >9.0%, , at least one ED visit in the past 12 months and/or have not received diabetes education within the past five years. Our annual ED visits are approximately 33,600. Those diagnosed with Diabetes as the primary or secondary diagnosis is 589.

Approximately 26% of our patients are either Medicaid eligible or indigent so we expect about 26% of the patients enrolled in the program to be Medicaid eligible or indigent.

Category 1 & 2 Expected Patient Benefit: I-17 Apply the chronic care model to targeted chronic diseases which are prevalent locally such as Diabetes. Of our target population, we expect 30% to be eligible or in need of a diabetes care model. Our baseline is zero as this is a new program at the hospital. In DY3 the goal is to begin providing care through the new program with 10 new patients receiving care under the chronic care management program by 9/30/14, increasing that number to 180 in DY4 with an additional improvement of 5% over DY4 in DY5.

I-18 Improve the percentage of diabetic inpatients with self-management goals. The baseline is zero as this is a new program at the hospital. The project seeks to improve number of diabetic ED patients with self-management goals from 0 to 5% of the target population (those identified above as eligible for the chronic care management program), or 9 patients in DY4 and an additional 5% or 18 patients in DY5.

Category 3 Outcome: IT-1.11 Diabetes care: Blood pressure control (<140/80mm Hg). Improvement Target: While the baseline is zero as this is a new program at the hospital, it is expected that 25% of the 180 eligible expected to be in the program or 45 patients will have controlled blood pressure. Therefore, in DY4, the goal is to increase the number of target patients in the program with controlled blood pressure by 1.5% and an additional improvement in DY5 of 1.5% over DY4.

IT-1.10 Diabetes care: HbA1c poor control (>9.0%). Improvement Target: While the baseline is zero as this is anew program at the hospital, it is expected that 65% of the target population or 117 patients will have uncontrolled A1c level. Therefore, in DY4, the goal is to decrease the number of target patients in the program with uncontrolled A1c levels by 1.5% with an additional decrease of 1.5% over DY4 in DY5.

IT-3.3 Diabetes 30 day readmission rate. Improvement Target: The target population in DY4 for this program is expected to be 10000 patients. Historically, the diabetes readmission rate is 6.8%. Therefore, we expect the diabetes 30-day readmission rate among this target population to be 6.8% or 13 patients. In DY4, the goal is to decrease diabetes 30-day readmissions to the hospital from this target population by 10% with an additional 10% reduction over DY4 in DY5.

These outcomes support the project's purpose because if we do a better job of keeping people's blood pressure and HbA1C levels within appropriate limits, it will lower readmissions and the cost associated with managing chronic conditions of our patients.

Project Description

This project will apply evidence-based care management models for ED patients identified as having high-risk health care needs associated with diabetes. The project will develop chronic disease management education, protocols and self-management criteria for patients through a multi-disciplinary process. These protocols, once developed will be implemented in the hospital through new outpatient and inpatient education services, through the network of primary care physicians and made available to community clinics supporting diabetic patients. Historically,

patients that do not effectively manage their diabetes tend to develop chronic diabetes complications, co-morbidities and lead to higher utilization and costs related to health care services. This program will be implemented to help those who need education on managing diabetes and providing monitoring services where they are being treated. Patients will be identified by partnering with primary care physicians, community clinics and inpatient nurse managers. Patients identified as having high risk needs associated with diabetes will be based on clinical protocols of A1C>9, at least one ED visit in the past year and/or have not received diabetes education within the past five years.

Goals and Relationship to Regional Goals

The goal of this project is to develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. The purpose for implementing a chronic disease management program for diabetes is based on hospital and community data. Diabetes related diagnoses account for the third highest patient segment for readmissions to the hospital. Diabetes management is also one of the top five community health needs with over 10% of the Dallas county population having been diagnosed with diabetes. The development and implementation of chronic disease management interventions for diabetes will lower costs and improve outcomes for the diabetic patients and community health status.

A major goal of the region is to improve the rate of chronic disease self-management and education. This project will contribute to that goal by providing patient education resources based on clinical management protocols.

Challenges

Hospital and market data indicates that approximately 40% of ED outpatient visits and 30% of inpatients with diabetes are Medicaid and uninsured patients. In the northern portion of the hospital service area 31% of the population is Hispanic and represents the fastest growing population segment. Hispanics are 1.5 times as likely to develop diabetes as non-Hispanic populations according to the CDC. Effective communication and creativity in reaching this community demographic has been identified as a challenge for this project.

5-Year Expected Outcome for Provider and Patients

- Formed multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar
- Developed a comprehensive diabetes care management program
- Developed and implemented plan for standing orders for diabetes patients

- Trained staff in the Chronic Care Model, including essential components of a delivery system that supports high-quality clinical and chronic diabetes management, and on the standing orders for diabetes patients
- Developed and implemented OP Diabetes Education Clinic and IP Educator program to assist patients to better self-manage their chronic diabetes
- Improved number of patients with self-management goals
- Improved number of patients being treated under the Chronic Care Model and/or Standing Orders for Diabetes

Starting Point/Baseline

Diabetes related diagnoses account for the third highest patient segment for readmissions to the hospital. Diabetes management is also one of the top five community health needs with over 10% of the Tarrant county population having been diagnosed with diabetes. The hospital currently does not offer outpatient diabetes education clinic services nor inpatient diabetes education. During DY2 and DY3 as the chronic health management program and clinical protocols for standing orders are developed, target populations will begin to be identified. Historically, the ED has seen approximately 589 patients that also have a principal or secondary diagnosis of diabetes. We expect to target 30% of those with the program; 25% (or 45) are expected to have controlled blood pressure and 65% (or 117) uncontrolled A1c levels >9.0%.

Rationale

Promoting effective change in provider settings to support evidence-based clinical and quality improvement across a wide variety of health care settings will make a significant improvement to the self-management of chronic conditions such as diabetes. CDC data indicates that almost half of all Americans, more than 145 million, live with a chronic condition. In the hospital market more than 10% of the population has been diagnosed with diabetes and the number is growing. More than half of individuals with a chronic condition have multiple conditions. The challenge in the community due to the lack of proper self-management of chronic conditions is higher rates of illness, higher utilization of high cost services and lower quality of life.

Project Components

The following core project components were selected because they are sequential steps necessary to implement the project and each is designed to apply evidence-based care management model to patients identified as having high-risk health care needs related to diabetes.

a. We will design and implement multi-disciplinary teams that are tailored to the patient's health care needs to include clinical nursing, physician representation as well as members from finance, patient education and existing employee medical home leadership.

b. Patients enrolled into the program will receive contact information from patient navigators to ensure that patients can access their care teams in person, phone or email

c. An integral part of this project is to provide patient education and self-management support. We will incorporate learnings from the hospital's current medical home and ACO initiatives to improve 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. We will conduct ongoing quality improvement efforts for the project. The hospital's quality committee of the board meets regularly to assess ongoing programs at the facility and will be used to evaluate the success and improvement opportunities of the chronic care management project as well.

Currently we use the Plan Do Check Act version of quality improvement for all of our programs at the hospital. We incorporate this process into any new program we do so that we embark with proper planning and have the systems in place to identify improvement opportunities throughout all stages of implementation.

Unique Community Need Identification Numbers the Project Addresses:

CN.9: Chronic Care

How the Project represents a new initiative

This project is a new initiative because the hospital does not have standing orders for diabetes protocols, does not offer dedicated diabetes education on self-management and has not received any other federal funding for it.

Related Category 3 Outcome Measure(s)

- IT-1.10: Diabetes Care: HbA1c poor control (>9.0%)
- IT-1.11: Diabetes Control: Blood pressure control (<140/80mm Hg)
- IT-3.3: Diabetes: 30-day Readmissions Rate

There are three Related Category 3 Outcome Measures for this project. The first two fall within Outcome Measure "Primary Care and Chronic Disease Management" (OD-1). Specifically the two Improvement Targets are IT-1.10 (Diabetes Care: HbA1c poor control (>9.0%)) and IT-1.11 (Diabetes Control: Blood pressure control (<140/80mm Hg)). This project will identify patients in the ED who are identified as having poor diabetes control. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market ultimately leading to better diabetes control outcomes.

The third Related Category 3 Outcome Measure falls within the Outcome Measure "Potentially Preventable Re-Admissions – 30-Day Readmission Rates" and IT-3.3 Diabetes 30 day readmission rate. This project will identify ED patients who have poor diabetes control and ultimately at high risk for readmission to the hospital. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market. Better preparing patients for self-management, education and ongoing support for diabetes care will ultimately lead to reduced diabetic re-admissions from this target population.

Our process milestones measure the development of chronic care management program for diabetes, training and education of care givers in multiple care sites, development of standing orders for diabetic patients and the development of a new Outpatient Diabetes Education service and new Inpatient Educator program. The Improvement milestones measure the number of individuals that will targeted for the education and self-management protocols, as well as the increased number of patients with self-management goals. The specific improvement targets for the number of patients provided services for education and the number of patients with self-management goals will be determined during DY2.

Relationship to Other Projects

- 126679303.2.1: Methodist Charlton Medical Center
- 135032405.2.2: Methodist Dallas Medical Center

This project will support, reinforce and enable the following Category 4, Reporting Domains through the project design and intervention for appropriate targeted patients:

- RD-1.2 (Preventable Admissions)-Diabetes Admission Rate
- RD-2.2 (Preventable 30 Day Re-Admissions)-Diabetes Re-Admission Rate

- RD-4.2 (Patient Centered Healthcare)-Medication Management

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

The RHP 9 projects regarding chronic care management are as follows:

Performing Provider	Unique Project	Project Option
Baylor University Medical Center	139485012.2.2	Expand Chronic Care Management Model – Diabetes (HbA1c poor control, BP control, foot exam)
Baylor Medical Center at Garland	121790303.2.2	
Baylor Medical Center at Irving	121776204.2.2	
Trinity Medical Center (Baylor-Carrollton)	195018001.2.1	
Children's Medical Center	138910807.1.3	Implement pediatric disease registry – asthma
Denton County HHS	13660803.2.1	Implement disease registry – diabetes
Methodist Charlton Medical Center	126679303.2.1	Expand Chronic Care Management Model – Diabetes (30-day readmission, Hba1c, BP control)
Methodist Dallas Medical Center	135032405.2.1	
Methodist Richardson Medical Center	209345201.2.1	
Parkland Health & Hospital System	127295703.1.3	Implement chronic care registry (Diabetes – retinal eye exam, 30-day readmissions)
Parkland Health &Hospital System	127295703.2.4	Expand Chronic Care Management Model – Diabetes (retinal eye exam; 30-day readmissions)
Texas Health Presbyterian Hospital Denton	020967801.2.2	Expand Chronic Care Management Model: Diabetes (HbA1c poor control, 30 day readmissions)
Texas Health Presbyterian Hospital Kaufman	094140302.2.2	
UTSW – Faculty Practice Plan	126686802.2.2	Expand Chronic Care Management Model (Diabetes: HbA1c control; All Cause Readmissions)

Plan for Learning Collaborative. We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an

annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

209345201.2.2	2.2.1	*2.2.1 (a-e)*	*Title: Expand Chronic Care Management Models*
Methodist Richardson Medical Center			*209345201*
Related Category 3 Outcome Measures:	*209345201.3.3* *209345201.3.4* *209345201.3.5*	*3.IT-1.10* *3.IT-1.11* *3.IT-3.3*	*Diabetes Care: HbA1c poor control* *Diabetes Care: Blood Pressure control* *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-4] Formalize multi-disciplinary teams, pursuant to the chronic care model defined by Wagner Chronic Care Model. Metric 1 [P-4.1]: Increase the number of multi-disciplinary teams Baseline = 0/Goal = 1 Data Source: Administrative records Milestone 1 Estimated Incentive Payment (max amount): $251,310 **Milestone 2** [P-3] Develop a comprehensive care management program Metric 2 [P-3.1]: Documentation of care management program Baseline = 0 /Goal: care management document Data Source: Administrative records Milestone 2 Estimated Incentive Payment (max amount): $251,311	**Milestone 3** [P-12] Develop and implement plan for standing orders Metric 1 [P-12.1] Documentation of plan for standing orders Baseline = 0 /Goal: care mgt document Data Source: Administrative records Milestone 3 Estimated Incentive Payment (max amount): $182,778 **Milestone 4** [P-2] Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care. Develop and implement plan for standing orders Metric 1 [P-2.1] Percent of staff trained Baseline/Goal: 0% / 5% Data Source: Administrative records Milestone 4 Estimated Incentive Payment (max amount): $182,778 **Milestone 5** [P-11] Develop and implement program to assist patient to better self-manage their chronic	**Milestone 6** [I-17] Apply the Chronic Care Model to targeted chronic diseases which are prevalent locally, such as diabetes Metric 1 [I-17.1]: Percent of diabetic ED patients receiving care under the Chronic Care model Baseline/Goal: 10/180 Data Source: Administrative records Milestone 6 Estimated Incentive Payment (max amount): $274,963 **Milestone 7** [I-18] Improve the percentage of diabetic inpatients with self-management goals Metric 1 [I-18.1]: Diabetic ED patients with self-management goals Baseline/Goal: 0/9 Data Source: Administrative records Milestone 7 Estimated Incentive Payment (max amount): $274,963	**Milestone 8** [I-17] Apply the Chronic Care Model to targeted chronic diseases which are prevalent locally, such as diabetes Metric 1 [I-17.1]: Percent of diabetic ED patients receiving care under the Chronic Care model Baseline/Goal: 180/increase of 5% over DY4. Data Source: Administrative records Milestone 8 Estimated Incentive Payment (max amount): $227,144 **Milestone 9** [I-18] Improve the percentage of diabetic ED patients with self-management goals Metric 1 [I-18.1]: Diabetic inpatients with self-management goals Baseline/Goal: 9 / 18 Data Source: Administrative records Milestone 9 Estimated Incentive Payment (max amount): $227,143

209345201.2.2	2.2.1	*2.2.1 (a-e)*	*Title: Expand Chronic Care Management Models*
Methodist Richardson Medical Center			*209345201*
Related Category 3 Outcome Measures:	*209345201.3.3* *209345201.3.4* *209345201.3.5*	*3.IT-1.10* *3.IT-1.11* *3.IT-3.3*	*Diabetes Care: HbA1c poor control* *Diabetes Care: Blood Pressure control* *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)**
	conditions <u>Metric 1</u> [P-11.1] Increase the number of patients enrolled in a self-management program Baseline/Goal: 0 /10 by 9/30/2014 Data Source: Administrative records Milestone 5 Estimated Incentive Payment (max amount): $182,776		
Year 2 Estimated Milestone Bundle Amount (add incentive payment amounts from each milestone): $502,621	**Year 3 Estimated Milestone Bundle Amount:** $548,332	**Year 4 Estimated Milestone Bundle Amount:** $549,926	**Year 5 Estimated Milestone Bundle Amount:** $454,287
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $2,055,166			

Project Option 2.1.1 – Enhance/Expand Medical Homes

Unique Project ID: 127295703.2.1

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. While Parkland's overall payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare and 7% Commercial Insurance, the Community Oriented Primary Care (COPC) clinic network's payer mix includes 62% Charity/Self Pay and 20% Medicaid.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY2012 Volumes	Parkland Share of Dallas County Adults	
		% Market Share	Medicaid/ Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Centers	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Intervention: Based on established criteria, Parkland will enroll patients into medical homes throughout the COPC network with specific physicians/care teams. This reorganization will require identification of potential medical home patients and provide care based on strict guidelines, such as the 2011 PCMH standards as identified by NCQA. Parkland will establish criteria, assign patients to medical homes and will connect patients in the hospital to medical homes through improved hospital care coordination including patient navigation and care transitions programs. Once assigned, patients will be managed utilizing the PCMH standards to improve their care and patient experience.

Need for Project: Parkland COPC clinics care for approximately 120,000 individuals (through approximately 400,000 visits per year). Of these, 40% have been identified initially to enroll in a medical home. This would reduce unnecessary utilization of the ED and other services (more than 12,000 adults and 12,500 children were seen at least 3 times at the COPCs in 18 months).

NCQA raised the bar with its PCMH 2011 Primary Care Medical Home recognition program and in a 2011 press release, NCQA stated the following: [317]

> "We revised the standards to be clearer and more specific, and some practices may find the program more challenging. Through a comprehensive review of new evidence on effective care practices, NCQA PCMH 2011 Advisory Committee discussions, feedback on our earlier programs and a public comment period, we have taken the program to a new level. Robust patient centeredness is an important program goal:
>
> - Stronger focus on integrating behavioral healthcare and care management
> - Patient survey results help drive quality improvement
> - Patients and their families are involved in quality improvement
>
> We have added a new, standardized patient experience survey and an accompanying standardized methodology."

The new standards have added significant changes that require process improvements for all of the COPC practices. Several elements were enhanced and new requirements were developed, all of which require significant practice changes throughout Parkland's community-based clinics where 120,000 individuals are cared for annually.

Target Population:

The target population for enrollment in the medical home model will be defined by established criteria. It is anticipated that initially 25,000 patients will be enrolled (82% of COPC patients are Medicaid/indigent patients). It is anticipated to enroll approximately 60,000 patients in a medical home model by DY5.

Category 1 & 2 Expected Patient Benefits: Patients assigned to a medical home will be better managed and prompted to utilize preventive services. This will reduce unnecessary ED visits and potentially preventable admissions and readmissions.

Category 3 Outcomes: The FY2016 outcomes for this project include:

- IT-1.2: Annual monitoring for patients on medications: ACE inhibitors or ARBS
    - Goal is to increase number of monitored CHF and Diabetes Patients
        - CHF: 83.7% (605 patients in FY12) to 88%;
        - Diabetes: 82.5% (2,282 patients in FY12) to 88%
- IT-1.12: Diabetes care: Retinal Eye Exam. Goal is to increase number of COPC patients who receive from 0 to 3,000

[317] National Committee for Quality Assurance. "NCQA's Patient-Centered Medical Home (PCMH 2011)." White Paper. Jan 2011.

- IT-1.20: Other - % patient who by age 13 years up-to-date with recommended immunizations: 1) MCV4 and 2) one Tdap/Td. Goal to increase to 80% compliance. (1,617/2,456 = 66% compliance in FY2012)

Project Description

Parkland will expand the medical home model throughout its COPCs by empaneling patients, identifying and extending care management to high risk/complex patients, sufficiently building the tracking and follow up systems to enhance referrals, and expanding reporting capabilities to provide physicians and care teams with information to improve care provided.

Such an elevation in performance will also provide Parkland the opportunity to achieve NCQA designation under the Patient-Centered Medical Home (PCMH) 2011 Program.

With twelve Community Oriented Primary Care (COPC) health located throughout Dallas County, Parkland is the largest provider of primary care for the population living at or below 200% of poverty, with approximately 120,000 individuals being seen in its primary care clinics (400,000 annual visits). At capacity already, the clinics must assess its abilities to identify patients and better monitor and manage care based on their specific medical home needs in hopes of improving outcomes and reducing unnecessary utilization of the care delivery system.

The 2011 PCMH standards require substantial changes/improvements in the current care model at Parkland's twelve COPC clinics including the following:[318]

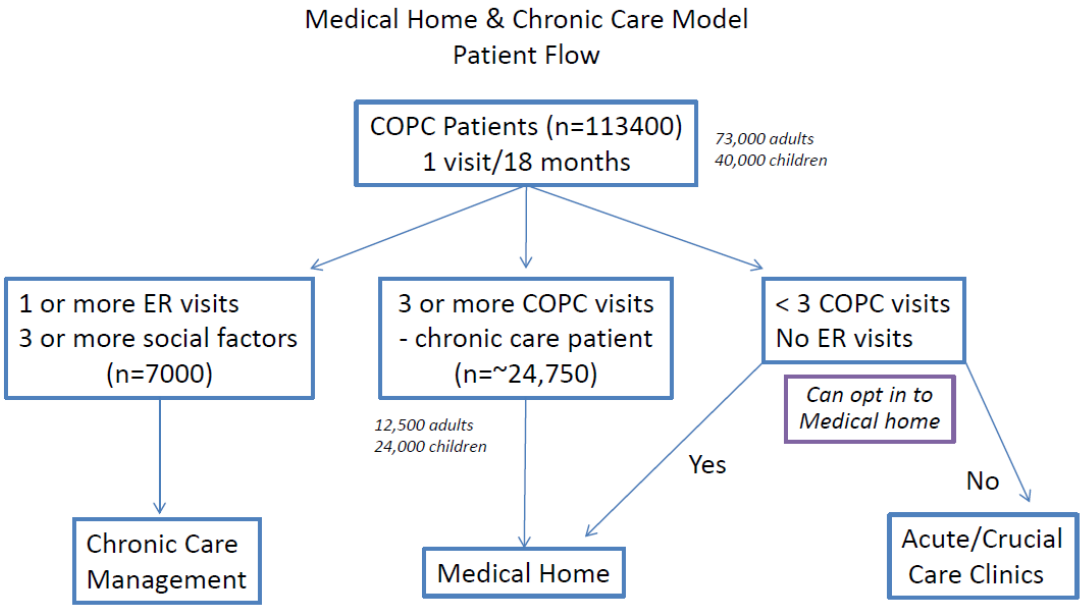
- Extends requirements of the primary care clinics and providers including offering extending hours of availability and electronic access to care teams
- Expands requirements for culturally linguistically appropriate services (CLAS)
- Expands Population Management
  - Requires identification of high risk/complex patients (new)
  - Asks practice to identify patients not recently seen by practice
  - Requires additional preventive care services and chronic care services
  - Includes preventive service reminders from PPC 3B
- Expands Care Management
  - Includes high-risk patients (new)
  - Record review increases from 36 to 48 patients
  - Requires provider to provide patient/family with clinical summary of visits
- Requires provision of referrals to Community Resources (new)
  - Requires practice to develop resource list on five key topics/key services of importance to patient population and to track referrals

[318] National Committee on Quality Assurance. 2011.

- Asks practice to arrange for or provide treatment for mental health and substance abuse disorders
- Requires offering opportunities for health education programs

- Requires additional Referral Tracking and Follow-Up including:
  - Establishing agreements with specialists
  - Electronic communication with specialist
- Requires additional categories of measurement: coordination, whole person care/self-management support in survey of patient experience
- Requires demonstrated Continuous Quality Improvement and emphasizes evaluation quality improvement by tracking results over time (new)
- Requires more specific alignment to Meaningful Use (new)
- Requires additional reporting of ambulatory clinical quality data, immunization data to registries/systems, syndromic surveillance data

To meet these requirements and build stronger relationships between care teams and patients, Parkland intends to assign patients to medical homes, monitor and track care and provide support to patients to better self-manage their conditions. The manner in which patients will be enrolled in a medical home and chronic care model is illustrated below:



Goals and Relationship to Regional Goals

The goal of this project is to expand the medical home concept through care management of patients who need primary and preventive services and can benefit from a medical home. Care management will be achieved through medical home care teams located at the COPC sites

throughout Dallas County. Objectives include: design and implementation of structural/ operational/ practice changes, conducting educational sessions for primary care physicians, care teams and specialists regarding elements of PCMH, its rationale and vision and collaborating with clinicians across the system in utilizing the medical home model in caring for a patient population.

This project relates to regional goals by improving access to primary care for all patients including those with low incomes and also improving care management of patients with chronic care needs through an evidence-based systematic care model such as that of the Patient-Centered Medical Home.

Challenges

Parkland has community-based practices that are currently providing care to patients beyond capacity and enrolling everyone who seeks care at Parkland in provider panels is not feasible. This project will focus efforts on identifying patients who require care through a medical home model.. This will require some shift in the health system's ability to provide acute care for those patients who do not want to be enrolled in a medical home but do require services from time to time.

Additionally, implementing the medical home model requires changing practice patterns and extensive disruptions to operations while providing care in an already over-burdened primary care system.

Another challenge is the intention/motivation of the patients. Parkland cares for many indigent and Medicaid patients and some of those patients will be willing to work with physicians and care teams to better self-manage their conditions and be compliant with treatment. Others may not be as compliant and may seek care as they need it in whatever setting (such as the ED). Providers may have every intention to manage the care for patients and work with patients to self-manage, insure referrals are made and care is monitored, but without the patient's commitment, there is little chance for success.

While the increased burden is challenging, Parkland is committed to PCMH principles and fully intends to focus efforts on improved care through standardized approaches to care, increased capacity and improved communications between providers and patients. Establishing criteria for enrollment, obtaining agreement between patients and providers to work through a medical home model, and following the NCQA 2011 PCMH guidelines in providing care will provide the best foundation for success.

5-Year Expected Outcome for Provider and Patients

Parkland will establish criteria for medical home assignment and track patient assignment of selected chronic care and prevention services to designated care teams. This will ensure that not only are more patients enrolled in medical homes, but their care is being tracked and

monitored to ensure the most appropriate care is being provided at the right time and in the right setting and that improvements in care are possible in time.

Another outcome is a better balance in the patients seen in the COPC who are enrolled in the medical home and those who use care infrequently and require little follow up. This will provide physicians the opportunity to see those patients who are enrolled in medical homes while the health system will direct patients with limited needs to another site, possibly the Acute Response Clinic (which is another project submitted for the waiver).

Starting Point/Baseline

In FY2012, Parkland provided care to 120,000 individuals (395,479 visits) in the COPC clinics. While many patients are eligible for enrollment in a medical home, initial focus will be on patients who meet specific criteria including utilization and chronic needs. The baseline is zero with 25,000 patients identified for initial enrollment.

Rationale

The Patient-Centered Primary Care Collaborative recently published its 2012 review of 46 medical home initiatives throughout the United States, *Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results*, which provides evidence that the patient-centered medical home model reduces costs and spending by reducing admissions and readmissions to hospitals and ED utilization.[319] Each initiative had some success, while most had significantly improved outcomes for patients. For WellMed in San Antonio, Texas, there was evidence of improved preventive care and disease management including:

- Increased control of HbA1C levels from 81% to 93% of diabetes patients
- Increased LDL levels under control, from 51% to 95%, for heart disease patients
- Improved diabetes HbA1c testing from 55% to 71%
- LDL screenings for all patients increased from 47% to 70%
- LDL screenings for diabetic patients increased from 53% to 78%

In its second year, Group Health Cooperative's Medical Home found implementation of a medical home concept resulted in cost savings, higher patient satisfaction and less provider burnout. The study found the enrolled patients had 29% fewer ED visits and 6% fewer hospitalizations.[320] Additionally, Group Health determined the return on investment was 5:1 (for every $1 they spent on implementing the PCMH model, they received a return of $1.50).

[319] Patient-Centered Primary Care Collaborative. *Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results. 2012.*

[320] Reid, RJ, et al. "The Group Health Medical Home at Year Two." Health Affairs 29, No. 5. 2010. P 835-843.

Parkland is making significant investments to increase capacity in primary and specialty care and to improve care coordination of inpatient/outpatient services. All of these efforts must connect the care delivery system for patients. The implementation of the electronic medical record and other investments in resources are foundational to improve communication and tracking of patients across the care continuum. Through these efforts, data will be reported that identifies high utilizers of services. Those patients, if they meet criteria, can be placed in a medical home that will improve care and reduce unnecessary use of other services.

Parkland has committed to meeting the new and more challenging 2011 PCMH standards in order to better meet the needs of this highly complex patient population. The 2011 standards for Patient-Centered Medical Home are grouped as follows[321]:

1) Improve Access/Continuity
2) Manage Patient Populations
3) Plan/Manage Care
4) Support Self-Care/Community Resources
5) Track/Coordinate Care
6) Measure/Improve Performance

Project Components

Parkland proposes to meet all required project components for this project including:

a. Utilize a gap analysis to assess and/or measure hospital-affiliated PCPs' NCQA PCMH readiness. *Parkland COPC leadership including physicians and other care team members will determine operational readiness to meet 2011 NCQA PCMH standards*.

b. Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status. *As the operational readiness assessment is completed, Parkland COPC leadership will determine appropriate steps to be taken to meet 2011 standards and develop a plan.*

c. Conduct educational sessions for primary care physician practice offices, hospital boards, medical staff and senior leadership on the elements of PCMH, its rationale and vision. *As the plan is implemented, providers and care team members will conduct sessions to educate physicians and care teams at other clinics regarding the PCMH model. Education will be ongoing and done regardless of achievement of recognition due to Parkland's commitment to the medical home model for its patient population.*

d. Conduct quality improvement for projects using methods such as rapid cycle improvements and participation in the regional learning collaborative. *This will be done*

[321] National Committee for Quality Assurance. Patient-Centered Medical Home Standards. 2011.

through collaboration with specialists and other primary care providers as well as hospital care transitions teams.

Milestones and Metrics

- P-2: Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and options for communication between patients, their personal physician and practice staff
    - P-2.1: Performing Provider policies on medical home
- P-6: Establish Criteria for Medical Home assignment for selected chronic care patients.
    - P-6.1: Determine criteria for Medical Home assignment
- P-7: Track assignment of patients to designated care team
    - P-7.1: Tracking Medical Home Chronic Care Patients
- P-11: Identify current utilization rates of preventive services and implement a system to improve rates among targeted population
    - P-11.1: Implement patient registry
- P-13: Review project data & respond with tests of new ideas, practices, tools, solutions
    - P-13.1: Number of new ideas, practices, tools, solutions tested
- I-12: Based on criteria, improve number of eligible patients assigned to medical home
    - I-12.1: Number of eligible patients assigned to a medical home, where "eligible" is defined by Provider
- I-17: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care
    - I-17.1: Reminders for identified patients 65 and over needing their pneumococcal vaccine
    - I-17.1: Number of diabetic patients receiving retinal exams in measurement year

Unique Community Need Assessment Identification Number:

- *CN.3 – Health Care Capacity*
- *CN.4 – Primary care and Pediatrics*

Why this is a significant enhancement to the current delivery reform initiative

This initiative will be a significant enhancement to Parkland's medical home model by meeting the more challenging 2011 PCMH standards and empaneling patients to improve care coordination and management.

The project has no related activities funded by U.S. Department of Health & Human Services.

Related Category 3 Outcome Measure(s)

OD-1: Primary Care and Chronic Disease Management

- IT-1.2: Annual monitoring for patients on persistent medications - ACE inhibitors/ARBs
- IT-1.12: Diabetes care: Retinal eye exam
- IT-1.20: Other: percentage of patients who by age 13 years were up-to-date with recommended adolescent immunizations: MCV4 and Tdap/Td

Annual monitoring for patients on persistent medications. Parkland has a significant number of patients on chronic medications needing to be monitored to decrease risk of adverse drug events from long-term medication use or misuse of medications. Persistent use of ACE Inhibitors or ARBs warrants monitoring and follow-up by the medical home to assess side-effects (i.e. loss of kidney function), and adjust drug dosage/therapeutic decisions accordingly.[322]

Diabetes: Retinal Eye Exam. Diabetic retinopathy, one of the leading causes of blindness in adults, can be treated if detected and addressed in the early stages.[323]

Primary Care and Prevention: Adolescent Immunizations (NQF 1407).[324] National Quality Forum Endorsed Measures include the following recommended immunizations for patients by age 13:

- TDaP vaccine which protects against tetanus, diphtheria and pertussis
- Meningococcal conjugate vaccine, which prevents meningococcal disease (10-14% of invasive meningococcal infections are fatal, and 11-19% result in long-term disability such as deafness, brain damage, or an amputated arm or leg)

[322] Jessup, M., et al. "*ACCF/AHA guidelines for diagnosis and management of heart failure in adults: a report of the American College of Cardiology Foundation/American Heart Association Task Force".* 2009. 119(14): p. 1977-2016.
[323] American Optometric Association. *Diabetes is the leading cause of blindness among most adults*. 2012; Available from: http://www.aoa.org/x6814.xml
[324] US Department of Health and Human Services, C.f.D.C.a.P., *Prevention and control of meningococcal disease: rcommendation of the Advisory Committee on Immunization Practices (ACIP).* Morbidity and Mortality Weekly Report, Recommendations and Reports, 2005. 54(RR07): p. 1-21.

Unique Identifier: *127295703.2.1*	***Project Option:*** *2.1.1*	***Project Components:*** *2.1.1 (a-d)*	***Title:*** *Expand Medical Home Model*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.15* *127295703.3.16* *127295703.3.17*	*3.IT-1.2* *3.IT-1.12* *3.IT-1.20*	- Annual monitoring for patients on medications: ACE inhibitors or ARBS – CHF and Diabetes Patients - Diabetes care: Retinal eye exam – NQF 0055 - Other: % patients by age 13 are up-to-date on recommended immunizations: MCV4 and Tdap/Td

Year 2 (10/1/2012 – 9/30/2013)	**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] Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and options for communication between patients, their personal physician and practice staff. Metric 1 [P-2.1]: Performing Provider policies on medical home Goal: Create policies Data Source: Provider's Policies and Procedures Milestone 1 Estimated Incentive Payment: $3,055,970 **Milestone 2** [P-6] Establish Criteria for Medical Home assignment for selected chronic care patients. Metric 2 [P-6.1] Determine criteria for Medical Home assignment Goal: Establish criteria Data Source: Submission of medical home assignment criteria	**Milestone 3** [P-7] Track assignment of patients to designated care team Metric 3 [P-7.1] Tracking Medical Home Chronic Care Patients Goal: Implement patient tracking Data Source: Tracking Report Milestone 3 Estimated Incentive Payment: $3,125,530 **Milestone 4** [P-11] Identify current utilization rates of preventive services and implement a system to improve rates among targeted population Metric 4 [P-11.1] Implement patient registry Goal: Implement use of registry Data Source: Patient Registry, EMR Milestone 4 Estimated Incentive Payment: $3,125,530	**Milestone 5** [I-12] Based on the criteria improve the number of eligible patients assigned to a medical home Metric 5 [I-12.1] Number of eligible patients assigned to a medical home, where "eligible" is defined by Performing Provider Baseline: 0 Goal: 37,500 Data Source: EMR, report Milestone 5 Estimated Incentive Payment: $3,120,684 **Milestone 6** [P-13] Review project data and respond with tests of new ideas, practices, tools, solutions Metric 6 [P-13.1] Number of new ideas, practices, tools, solutions tested Baseline/Goal: 0/TBD Data Source: Description of ideas tested; summarized quarterly Milestone 6 Estimated Incentive Payment (max amount): $3,120,684	**Milestone 7** [I-17] Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care Metric 7 [I-17.1] Reminders for identified patients 65 and over needing their pneumococcal vaccine. Goal: 75% of identified patients contacted for vaccine Data Source: Registry, or other documentation Milestone 7 Estimated Incentive Payment: $2,519,807 **Milestone 8** [I-12] Based on the criteria improve the number of eligible patients assigned to a medical home Metric [I-12.1] Number of eligible patients assigned to a medical home, where "eligible" is defined by Performing Provider Goal: 60,000 enrolled

Unique Identifier: *127295703.2.1*	***Project Option:*** *2.1.1*	***Project Components:*** *2.1.1 (a-d)*	***Title:*** *Expand Medical Home Model*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.15* *127295703.3.16* *127295703.3.17*	*3.IT-1.2* *3.IT-1.12* *3.IT-1.20*	- Annual monitoring for patients on medications: ACE inhibitors or ARBS – CHF and Diabetes Patients - Diabetes care: Retinal eye exam – NQF 0055 - Other: % patients by age 13 are up-to-date on recommended immunizations: MCV4 and Tdap/Td

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
such as patients with specific chronic conditions. Milestone 2 Estimated Incentive Payment: $3,055,969			Data Source: EMR, report Milestone 8 Estimated Incentive Payment: $2,519,807
Year 2 Estimated Milestone Bundle Amount: $6,111,939	**Year 3 Estimated Milestone Bundle Amount:** $6,251,060	**Year 4 Estimated Milestone Bundle Amount:** $6,241,368	**Year 5 Estimated Milestone Bundle Amount:** $5,039,614
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):*			**$23,643,981**

Project Option 2.2.1 – Expand Chronic Care Management Model

Unique Project ID: 127295703.2.4

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's overall payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare, and 7% Commercial Insurance and the COPC network's payer mix includes 62% Charity/Self Pay and 20% Medicaid.

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Ambulatory Visits	1,031,311	n/a	n/a
- Community Health Center	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Intervention: Parkland will incorporate into its care delivery system a chronic care model based on the Wagner Chronic Care Model,[325] modified, as appropriate, for Parkland's low income patient population.

Need for the Project: The need for better management of patients with chronic conditions is high in the region and at Parkland specifically. It has been estimated that 30,000 of Parkland's patient population are diabetic. Creating the registry as identified in a related project will allow Parkland to identify these patients ~~as well as patients~~ with other chronic conditions for proactive management. Proactive management of patients with chronic disease can improve

[325] Wagner, E, Austin, B, Davis, C, Hindmarsh, M, Schaefer, J, Bonomi, A. "Improving Chronic Illness Care: Translating Evidence into Action." Health Affairs, Volume 20, Number 6. 2001.

the quality of life for patients as well as decrease high cost utilization within the healthcare system such as in the ED.

Target Population: Initially, Parkland will focus on enrolling patients with Diabetes, Congestive Heart Failure (CHF) into a chronic care model. In subsequent years, patients with other conditions – Chronic Kidney Disease (CKD), COPD, Hypertension, pediatric asthma, pediatric obesity – will be enrolled into the chronic disease management model. Initial projections estimate those to be enrolled in a chronic care model at 15,000-20,000 by DY5.

Category 1 & 2 Expected Patient Benefits: The goal is to increase the number of patients who are enrolled with a care team and cared for utilizing an evidence-based care model.

Category 3 Outcomes: Parkland has identified the following FY2016 clinical outcomes:

- IT-1.2: Annual monitoring of patients on persistent medications (ACE inhibitors/ARBs)
    - Goal: Increase the number of monitored patients on persistent medications
        - CHF: 83.7% (605 patients in FY12) to 88%;
        - Diabetes: 82.5% (2,282 patients in FY12) to 88%
- IT-1.12: Diabetes: Retinal eye exam
    - Goal (COPCs): Increase number of patients who receive exams from 0 to 3,000
    - Goal (Family Medicine): Increase percentage of patients who receive eye exams from 48% (235/483 patients in FY2012) to 80%
- IT-3.3: Diabetes 30-day Readmission Rate
    - Goal: Decrease the rate of readmissions from 9.2% (117 in FY12) to 8.7%

Project Description

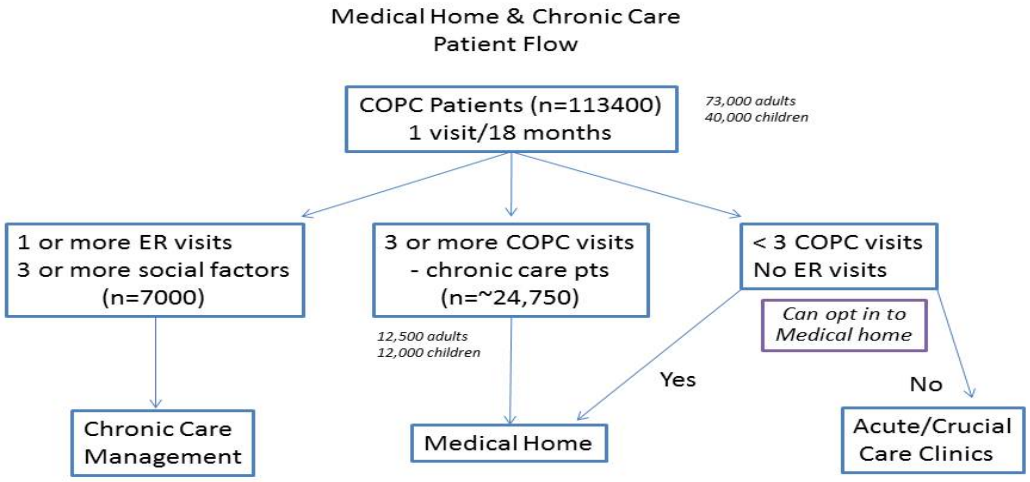
Parkland will incorporate evidence-based chronic care model into practice for patients with specified chronic conditions.

Based on evidence-based care models, a team of providers will focus efforts on the implementation of a Chronic Care Model for management of diabetes, chronic kidney disease and congestive heart failure for Parkland's patients. A Chronic Care Model developed by Edward H. Wagner has been widely accepted for its success and is categorized into four elements: 1) increased provider expertise and skill, 2) educating and supporting patients, 3) making care delivery more team-based and planned, and 4) making better use of registry-based information systems[326]. As Parkland incorporates a chronic care model, elements of the Wagner model will be incorporated as appropriate.

[326] Katie Coleman, Brian T. Austin, Cindy Brach and Edward H. Wagner., "Evidence On The Chronic Care Model In The New Millennium," *Health Affairs*, 28, no.1, 2009:75-85.

The physicians leading this effort established a pilot project to implement a chronic care model for CHF patients and are expanding that pilot to other sites as well as expanding the targeted chronic conditions. Care teams (physicians and non-physicians) will be placed within the community practices where primary care is provided and will have access to patient stratification tools, a registry and other information systems to assist in their provision of care as well as provide results-oriented information for continued improvement of the model. Additionally, patients will be provided information and tools to assist in self-management of their conditions.

The manner in which patients will be enrolled in a medical home and chronic care model is illustrated below:



Goals and Relationship to Regional Goals

The goal of this project is to implement a chronic care model that provides a framework for care teams including interventions to improve outcomes for patients with chronic conditions.

Regional goals include improved access to care, improved care coordination and management and improved provider performance and outcomes. This project will support coordination of care through an established model for patients with specified conditions. Registries will be set up to monitor and track progress. Care teams will be established to include physicians and other clinicians as well as representatives from nutrition, pharmacy, social services, etc. Establishment of such a care model will provide downstream benefits including a reduction of capacity constraints by reducing the number of unnecessary ED visits and readmissions

Challenges

Nationally 57% of people with chronic conditions are privately insured but have significant out-of-pocket costs, 85% of the Medicare elderly have chronic conditions and more than 8 million people who have chronic conditions are uninsured.[327] Providing adequate care to people with chronic conditions is an extensive effort as such conditions impact people's physical and mental health and their social and professional lives. The question no one can answer is who should coordinate and finance "life care" for those with chronic conditions. Health care providers can only provide support to patients while they are being treated within the system. Contributing to that question, other major challenges in implementing a chronic care model are as follows:

1) Parkland's patient population, having less access to resources at home and within the community, may be less likely to follow stringent self-management plan for their conditions. Indigent patients have limited resources and may be required to choose between needs for themselves and possibly their families as living "paycheck to paycheck" proves true.

2) There is a lack of community resources for patients who need chronic care management. Studies have shown there are few health store options and or gyms/parks in areas where Parkland's patients reside. Without community resources, patients have fewer opportunities to care for themselves. While community resources are factor for success, support for community organizations is limited and the economic model to support preventive care does not exist.

4) Parkland has capacity constraints at every entry point. Some community practices have wait times for appointments 9-12 months out. In order to implement such a model, several things must occur simultaneously. For example, chronic patients must be identified and those patients must then be enrolled with care teams who may already have patients scheduled months out. Rearranging provider schedules and care teams is a significant undertaking as Parkland sees more than 15,000 outpatient/ambulatory visits on any given day.

5-Year Expected Outcome for Provider and Patients

~~The pilot goal is to have 3,500 patients enrolled in a registry and set up with a care team for chronic care management.~~ Expected outcomes for patients enrolled in a chronic care model will be improved patient outcomes and improved quality of life for patients with chronic conditions such as Diabetes and CHF. Providers will utilize guidelines for evidence-based care protocols for specific conditions that will provide point of care, between care and post care interventions insuring the patient's care is planned and objectives of care are met even between visits.

<u>Starting Point/Baseline</u>

[327] Johns Hopkins Partnership for Solutions. "Chronic Conditions: Making the Case for Ongoing Care". Sept 2004 Update.

Because the Chronic Care Model has not been implemented yet, the starting point/baseline is zero (0). The initial pass of potential patient candidates for enrollment in a chronic care model includes 7,000 diabetic and CHF patients who have utilized the COPC network 3+ times in 18 months. Additionally, 6,500 pediatric patients have been identified with asthma or obesity for an estimated total of 13,500 patients as a "target" base.

Rationale

According to the Centers for Disease Control approximately 133 million Americans (nearly 1 in 2 adults) live with at least one chronic illness and the percentage of U.S. children and adolescents with chronic health conditions has increased from 1.8% in the 1960s to more than 7% in 2004.[328]

With more than 75% of health care costs due to chronic conditions[329], the health care delivery system must decipher the need by condition in order to make any significant contributions to improved care. According to the Healthcare Advisory Board, over the last 25 years the largest growth in health care costs for chronic disease has shifted among conditions, from heart conditions, COPD and mental disorders (1987-1997) to cancer, hypertension, chronic kidney disease and diabetes (1997-2007), with the largest increase in costs attributed to diabetes[330]. The American Diabetes Association states the national cost of diabetes exceeds $174 billion including $116 billion in excess medical expenditures and $58 billion in reduced national productivity.[331] People with diagnosed diabetes, on average, have medical expenditures that are approximately 2.3 times higher than the expenditures would be in the absence of diabetes Indirect costs of diabetes include factors related to absenteeism and reduced productivity.

Parkland has approximately $1.1 billion in annual operating revenues and $1.5 billion in annual operating costs, thus the cost-effectiveness of incorporating a chronic care model in provider practices is imperative. One study performed through extensive literature review of other intervention studies incorporating a chronic care model found that utilization of a chronic care model was cost-effective and provided improved outcomes.[332]

Other research showed that interventions based on chronic care model components improved at least 1 process or outcome measure for diabetic patients. Another study in Pennsylvania for the underserved population indicates that the patients who were seen at a site that followed CCM had improved HbA1C levels, non-HDL cholesterol levels and rates of self-monitoring of blood glucose.[333] The study indicated patients were significantly more likely to report having received preventive procedures, tests, foot and eye exams and medication reviews. The ED utilization measured by average ER visits per year was lower for those after 24 months of

[328] Centers for Disease Control 2012. http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.html
[329] Centers for Disease Control 2012. http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.html
[330] Thorpe K et al., "Chronic Conditions Account for Rise in Medicare Spending 1987-2006," Health Affairs, Apr 2010:718-724.
[331] American Diabetes Association 2012. http://www.diabetes.org/advocate/resources/cost-of-diabetes.html
[332] Katie Coleman, Brian T. Austin, Cindy Brach and Edward H. Wagner. "Evidence On The Chronic Care Model In The New Millennium." *Health Affairs*, 28, no.1 (2009):75-85. doi: 10.1377/hlthaff.28.1.75
[333] Wagner EH et al. "Chronic Care Clinics for Diabetes in Primary Care." *Diabetes Care*, No.4, April 2001: 695-700.

initializing these CCM interventions. Regarding whether chronic care model interventions can reduce costs, 18 of 27 studies concerned with 3 examples of chronic conditions (congestive heart failure, asthma, and diabetes) demonstrated reduced health care costs or lower use of health care services.[334]

Project Components

a) Design and implement care teams that are tailored to the patient's health care needs. *Care teams will be established as patients are identified, enrolled and needs are assessed.*

b) Ensure that patients can access their care teams in person or by phone or email. *As the care teams are established, accessibility will be addressed and patients will be notified.*

c) Increase patient engagement through patient education, group visits, self-management support, improved patient-provider communication and coordination with community resources. *While this is imperative to success of the model, there must be some innovative methods to assist those patients who may be less compliant in self-management*.

d) Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions. *Parkland patients have access to MyChart (self-management tool) but require education regarding the tool. Patients will also have access to primary and preventive care that can be coupled with other Parkland services including ADA-certified diabetes self-management classes and pharmacy services provided by pharmacists who are certified diabetes educators*.

e) Conduct quality improvement for project using methods such as rapid cycle improvement. *As the chronic care model and registry proves successful, patients with other conditions will be included working with hospital care transitions teams, primary and specialty care faculty and the Clinical Innovations Center to expand the models for other conditions.*

Milestones and Metrics

- P-3: Develop a comprehensive care management program
    - P-3.1: Documentation of care management program
- P-1: Expand chronic care model to primary care clinics
    - P-1.1: Increase # primary care clinics using chronic care model
- P-4: Formalize multi-disciplinary teams, pursuant to chronic care model defined by Wagner Chronic Care Model or similar

[334] Thomas Bodenheimer, MD; Edward H. Wagner, MD, MPH; Kevin Grumbach MD. *JAMA.* 2002; 288(15):1909-1914.

    - P-4.1: Increase number of multi- disciplinary teams or number of clinic sites with formalized teams
- P-9: Develop program to identify and manage chronic care patients needing further clinical intervention
    - P-9.1: Increase number of patients identified as needing preventive tests or other clinical services
- P-15: Review project data and respond with tests of new ideas, practices, tools, solutions
    - P-15.1: Number of new ideas, practices, tools, solutions tested
- I-17: Apply Chronic Care Model to targeted chronic diseases, which are prevalent locally
    - I-17.1: Increase number of additional patients who receive care under CCM for chronic disease

Unique Community Need Identification Numbers the Project Addresses

- *CN.9 – Lack of Care Coordination for Chronic Disease*. For ED utilization in the region within the top seven diagnoses, 20-45% had an underlying condition of diabetes and the top condition for ED use among Medicaid and the uninsured adults was diabetes between 2010Q3 and 2011Q3.

How the Project represents a new initiative

This project is a new initiative and provides a new opportunity to establish an evidence-based chronic care model to be incorporated into physician practices at Parkland.

The project has no related activities funded by U.S. Department of Health & Human Services.

Related Category 3 Outcome Measure(s)

OD-1: Primary Care and Chronic Care Management
- IT-1.2: Annual monitoring of patients on persistent medications (ACE inhibitors/ ARBs)
- IT-1.12: Diabetes: Retinal eye exam (NQF 0055)

OD-3: Potentially Preventable Readmissions
- IT-3.3: Diabetes 30-day Readmission Rate

Reasons/Rationale for selecting outcome measures

Diabetes has been identified as the initial focus for implementation of the Chronic Care Model. It has been estimated that approximately 10% of Parkland's patients are diabetic thus lending

itself to establishment and implementation of a chronic care model around diabetes management.

Diabetes is one of the most costly and prevalent chronic disease in the United States. Recent estimates have shown that patients with HbA1c > 9.0 had on average $5,000 in hospital costs, while those with a lower HbA1c (<7.0) had only $2,700 in hospital costs.[335] In Texas, diabetes affects 10% of the population (national average 8%) and in Dallas County diabetes affects 11.4% of the population.

Relationship to Other Projects

Parkland intends to balance the care continuum to insure those patients who need a medical home and/or require care through a chronic care model have access and also assure that the patients who do not need a medical home but require occasional medical care also receive the care they need in the right setting. All Parkland projects address a key component of the care continuum that must be addressed to find the right balance. This balance will insure all patients get the right care at the right time in the right place

A key element of a chronic care model is the utilization of patient data through a patient registry and so the registry project will be implemented with this project. Other related projects include the following:

Unique Project	Option	Project Description
127295703.2.1	2.1.1	Expand medical home model (COPCs)
127295703.1.3	1.3.1	Implement a chronic disease registry
127295703.2.10	2.1.1	Expand medical home model (Family Medicine)

Category 4 Related Outcomes

- RD-2: Potentially Preventable Readmissions for Diabetes
- RD-5: Emergency Department
- RD-6: Initial Core Set of Health Care Quality Measures
    - Comprehensive Diabetes Care
    - Annual monitoring for patients on persistent medications

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

Related projects (2.2) submitted by other performing providers in RHP 9 include the following:

Performing Provider	Unique Project	Project Option
Baylor University Medical Center	139485012.2.2	Expand Chronic Care Management Model – Diabetes (HbA1c poor control, BP control, foot
Baylor Medical Center at Garland	121790303.2.2	

[335] Menzin, J, Korn, J, Cohen, J, et al. "Relationship between glycemic control and diabetes related hospital costs in patients with type 1 or type 2 diabetes mellitus. Journal of Managed Care Pharmacy. May 16, 2010. Vol 16(4): 264-75.

Baylor Medical Center at Irving	121776204.2.2	exam)
Baylor – Carrollton (Trinity Medical Center)	195018001.2.1	
Denton County Health & Human Services	136360803.2.1	Implement disease registry – diabetes
Methodist Charlton Medical Center	126679303.2.1	Expand Chronic Care Management Model – Diabetes (30-day readmission, Hba1c, BP control)
Methodist Dallas Medical Center	135032405.2.1	
Methodist Richardson Medical Center	209345201.2.1	
Texas Health Presbyterian Hospital Denton	020967801.2.2	Expand Chronic Care Management - Diabetes (HbA1c poor control; Readmissions)
Texas Health Presbyterian Hospital Kaufman	094140302.2.2	
UTSW – Faculty Practice Plan	126686802.2.2	Expand Chronic Care Management-Diabetes

We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational *impact*, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted score of 8.7 on a 9.0 scale. Factors that influenced this score included:

- The strong impact this project will have with respect to managing, at the health system level, the patients among Parkland's vulnerable population affected by chronic disease and at highest risk for costly health exacerbations
- Alignment with the community need for chronic disease management
- Cost avoidance by providing increased opportunity for patients in this community to obtain the right care in the right place at the right time
- Opportunities for partnership and collaboration with the many performing providers in **RHP** 9 that are pursuing the chronic disease management projects

Health Management Associates (HMA) published a paper in November 2008 that surveyed the literature with respect to evidence of savings associated with chronic disease management.[336] The paper indicates evidence that chronic disease management programs can yield savings

[336] Chronic Disease Management: Evidence of Predictable Savings, Health Management Associates; Jack Meyer, PhD and Barbara Markham Smith, JD November 2008.

ranging from 2.72 to 32.7 dollars saved per dollar invested. The paper also notes that costs tend to be relatively modest, ranging from $100 to $1399 per capita. These factors are extended with respect to the Parkland enrollment targets in the table below.

Parkland Program Enrollees	Potential Per Capita Program Costs	Ratio of Dollars Saved to Dollars Spent	Potential Value Range
10,000	$100 - $1399	2.72 to 32.70	$2,720,000 – $457,473,000
15,000	$100 - $1399	2.72 to 32.70	$4,080,000 – $686,209,500

The range of potential value is extremely wide, but demonstrates the potential for significant value to be produced by the design and implementation of organized chronic disease/condition management programs.

Unique Identifier: *127295703.2.4*	***Project Option:*** *2.2.1*	***Project Components:*** *2.2.1 (a-e)*	***Title:*** *Expand Chronic Care Management Model*	
Parkland Health & Hospital System				*127295703*
Related Category 3 Outcome Measures:	*127295703.3.22* *127295703.3.23* *127295703.3.24*	*3.IT-1.2* *3.IT-1.12* *3.IT-3.3*	*Annual monitoring of patients on medications – ACE inhibitors or ARBs* *Diabetes Care: Retinal Eye Exam* *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-3]: Develop a comprehensive care management program Metric 1 [P-3.1]: Documentation of care management program Goal: Implement chronic care management model for COPCs Data Source: Program materials; Care model documentation Milestone 1 Estimated Incentive Payment (max amount): $ 4,028,323 **Milestone 2** [P-1]: Expand chronic care model to primary care clinics Metric 2 [P-1.1]: Increase # primary care clinics using chronic care model Goal: Incorporate chronic care model at COPCs Data Source: documentation of practice management Milestone 2 Estimated Incentive Payment (max amount): $ 4,028,324	**Milestone 3** [P-4]: Formalize multi-disciplinary teams, pursuant to chronic care model defined by Wagner Chronic Care Model or similar Metric 3 [P-4.1]: Increase number of multi- disciplinary teams or number of clinic sites with formalized teams Goal: Teams at more sites of care Data Source: Documentation Milestone 3 Estimated Incentive Payment (max amount): $ 4,120,016 **Milestone 4** [P-15]: Review project data and respond with tests of new ideas, practices, tools, solutions. Metric 4 [P-15.1]: Number of new ideas, practices, tools, solutions tested Goal: Increase number of ideas Data Source: Description of ideas, practices; summarized quarterly Milestone 4 Estimated Incentive Payment (max amount): $ 4,120,017	**Milestone 5** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention Metric 5 [P-9.1]: Increase number of patients identified as needing preventive tests or other clinical services Goal: Identify 100% of patients in registry who need preventive or other clinical service Data Source: EHR, Patient registry Milestone 5 Estimated Incentive Payment (max amount): $4,113,629 **Milestone 6** [I-17]: Apply Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 6 [I-17.1]: Increase number of additional patients who receive care under CCM for chronic disease Baseline: 0 Goal: 15,000 enrollees	**Milestone 7** [I-17]: Apply Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 7 [I-17.1]: Increase number of additional patients who receive care under CCM for chronic disease Baseline 0/~~3,500~~ Goal: 20,000 enrollees Data Source: Registry Milestone 7 Estimated Incentive Payment (max amount): $6,643,128

<table>
<tr><td>Unique Identifier:
127295703.2.4</td><td>Project Option:
2.2.1</td><td>Project Components:
2.2.1 (a-e)</td><td colspan="2">Title: Expand Chronic Care Management Model</td></tr>
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127295703.3.23
127295703.3.24</td><td>3.IT-1.2
3.IT-1.12
3.IT-3.3</td><td colspan="2">Annual monitoring of patients on medications – ACE inhibitors or ARBs
Diabetes Care: Retinal Eye Exam
Diabetes: 30-Day Readmission Rate</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td></td><td></td><td>Data Source: Patient Registry

Milestone 6 Estimated Incentive Payment (max amount): $4,113,629</td><td></td></tr>
<tr><td>Year 2 Estimated Milestone Bundle Amount; $8,056,647</td><td>Year 3 Estimated Milestone Bundle Amount: $8,240,033</td><td>Year 4 Estimated Milestone Bundle Amount: $8,227,258</td><td>Year 5 Estimated Milestone Bundle Amount: $6,643,128</td></tr>
<tr><td colspan="3">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):</td><td>$31,167,066</td></tr>
</table>

Project Option 2.5.2 – Assess Cost Effectiveness of Continuum of Care Alternatives

Unique Project ID: 127295703.2.5

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare and 7% Commercial Insurance.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY2012 Volumes	Parkland Share of Dallas County Adults	
		% Total Adult	Medicaid/ Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Centers	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Parkland directly employs approximately 150 primary care physicians (pediatrics, family medicine, internal medicine) who provide services in the community health centers. Campus based physician services are provided mainly by UT Southwestern Medical Center faculty under a services contract.

Intervention: Implement a cost accounting system and develop a standardized, evidence-based methodology to determine cost effectiveness. Use the assessment of post-acute continuum resources as the pilot for the new system and methodology. The standardized methodology and associated tools will be used to inform care continuum related decisions that will impact the entire Parkland system and the approximately 290,000 individuals it serves. As a safety-net

system, the majority (approximately 80%) of the patients impacted will be Medicaid and Indigent.

Need for the Project: While the Parkland system exists to furnish care to the low income residents of Dallas County, the demand for patient care services far exceeds the capacity of the system. It is important that Parkland establish the tools and methodologies to assure that its resources are being directed in the most effective way possible. This project is designed to implement the cost accounting tools that will support the development of a standardized, evidence-based methodology for informing effective resource allocation decisions.

Target Population: The target population includes the low income residents of Dallas County who are encompassed by Parkland's mandate.

Category 1 & 2 Expected Patient Benefits: The Parkland system will have the basis to inform decisions to allocate resources to best serve the low income residents of Dallas County

Category 3 Outcomes: The FY2016 outcomes for this project include:

- IT-5.1: Improved cost savings. Goal: Using the Cost Minimization analysis, achieve a system-wide reduction in cost associated with the pilot project of at least .5% (equates to approximately $5 million impact on direct medical costs)

- IT-5.2: Per episode cost of care. Goal: Evaluate the pre- and post- cost per episode of care the target population in the pilot and achieve cost saving of at least 10%

Project Description

This project will produce a tested, replicable methodology using well developed cost-accounting data for the Parkland System to evaluate resource allocations for expansions, contractions or changes of its care continuum with the objective of providing better integrated, patient-centered and cost effective care delivery.

The demand for indigent patient care services far exceeds the capacity of the Parkland system. To address this challenge in a systematic way, Parkland will implement a cost-accounting system module and establish an evidence-based methodology to evaluate and inform resource allocation decisions.

The cost accounting system will provide foundational product/process fixed/variable cost information and provide the tools to assemble episode of care and system of care cost information. This information, aligned with a cost-effectiveness methodology will provide the infrastructure necessary to position the system to make well informed decisions that consider both cost and effectiveness of care.

There has been significant discussion of the need to expand the Parkland system care continuum into the post-acute care arena. This question requires evaluation of both the cost-

effectiveness of the episode of care and to the system of care. Because this question would serve as an excellent pilot subject, this project proposed to include a test of the development with a proposed allocation of resources to the post-acute care arena.

Goals and Relationship to Regional Goals

The goals of this project are to:

1. Implement a cost-accounting module and develop a robust cost effectiveness methodology
2. Test and refine the methodology through its application to a pilot project regarding the allocation of resources to post-acute care services
3. Generalize and disseminate the methodology so that it will be used as the basis of all system-related care continuum assessments.

RHP 9 goals include improved access to care, improved care coordination and improved provider performance and outcomes. This project will provide cost savings to Parkland and to Dallas County, thus providing opportunities to provide more care to other patients in need.

Challenges

The Parkland System does not consistently utilize a standardized, best-practice methodology for evaluating the impact of investments in or changes to the care continuum. Further, the system's cost accounting technology and expertise are not sufficiently developed to provide the needed support for this type of impact analysis.

The system must commit to the design and standardized use of well-developed tools and evidence-based methodologies to assure meaningful and consistent decision making regarding system resource allocation.

5-Year Expected Outcome for Provider and Patients

The 5-year expected outcomes of this project specifically address the development and generalized to implementation of standards and best-practices that will assure better system-wide decision making and resource deployment. Through the project, Parkland believes that it will produce a lower Per Episode Cost of Care and demonstrate a better utilization of acute care resources.

Starting Point/Baseline

Parkland does not currently have robust cost accounting tools and methodologies. Baselines related to cost will be used in the measurement of project success will be developed in DY3.

Rationale

Most health care organizations confront access and throughput demands. Throughput is particularly challenging for the public health providers caring for a large population of uninsured, indigent patients for whom there are few options for health care services. Over the last several decades, the Parkland system has grown and expanded its care continuum in a somewhat fragmented way, now providing health care services in the primary care, specialty care and acute hospital care settings. Annually, the system cares for approximately 290,000 individuals - a penetration rate between 25 and 30 percent of the mandate population. Each of its care environments functions effectively at capacity – which produces access and throughput gridlock.

At this time, the Parkland system does not utilize a standardized, robust, best-practice methodology for system based decision making framing both financial and non-financial factors. Through this project, Parkland will establish the cost accounting tools to produce meaningful cost data to supply key financial factors for decision making. The cost accounting methodology and tools will support the use of two cost analysis methods:

- Cost (per episode) of Illness – comparison of costs of the design alternatives against the baseline cost per episode of care
- Cost Minimization – determining least costly alternative to produce an equivalent outcome

These factors serve as critical elements to the decision making process.

Pilot to Test and Refine Methodology

It is believed that the Parkland system should consider expansion of its care continuum to include post-acute care services potentially including some or all of the following:

- Long-term care hospital – which treats patients who stay more than twenty-five days and suffer from clinically complex problems

- Skilled nursing facility – which provides daily inpatient skilled care by nurses under a physician's plan of care

- Home with services from a home health agency – which provides skilled care to homebound patients consistent with physicians' orders and physicians' assessments. Care includes therapy, nursing care and assistance from home health aides.

As a result, many Parkland patients remain in the acute care setting consuming higher resource levels than is appropriate to their needs. For this project, it is proposed that the post-acute

development consideration serve as a meaningful and significant pilot to test and refine the cost accounting tools and methodologies.

Project Components

There are no required core components for 2.5.2 - Implement other evidence-based project to redesign for cost containment in an innovative manner not provided in other project options.

Milestones and Metrics

- P-1: Develop a cost-accounting methodology to quantify financial impact of quality/efficiency improvement interventions.
    - P-1.1: Cost-accounting methodology
- P-3: Implement the cost-accounting methodology and related systems to measure intervention impacts
    - P-3.1: Cost-accounting system
- P-2: Establish baseline for cost
    - P-2.1: Establish baseline for cost
- P-4: Conduct cost analysis
    - P-4.1: Cost analysis or results – submission of cost analysis plan or results
- P-7: Quality Improvement Milestone: Bi-weekly collaborative
    - P-7.1. Number of bi-weekly meetings, conference calls, or webinars organized
    - P-1.2: Share Challenges and solutions
- I-7: Measure cost containment by re-measuring healthcare costs of an intervention and compare to baseline to gauge improvements in cost – *using the post-acute care pilot as the basis for re-measurement.*
    - I-7.1: Ratio of Post-Intervention Care Delivery to Baseline
- P-5: Train finance staff on costing methodologies and define, develop, document methodologies with departments for allocation of costs to specific services
    - P-5.1: Staff trainings and department specific methodologies – submission of training and department documents
- I-11: Improvements in cost containment using innovative project option.
    - I-11.1: Total cost per member of the population per month
    - I-11.2: Hospital and ED utilization rates per episode cost of care

Unique Community Need Identification numbers the Project Addresses

- *CN.12 – Emergency Department Usage and Readmissions*

How the project significantly enhances an existing delivery system reform initiative

This project will establish a standardized approach and methodology for the Parkland system to inform resource allocation to produce improved cost-effectiveness both in episodic care and in the care system in total.

The project has no related activities funded by U.S. Department of Health & Human Services.

Related Category 3 Outcome Measure(s)

OD-5: Cost of Care

- IT-5.1: Improved Cost savings: demonstrate cost savings in care delivery
- IT-5.2: Per episode cost of care

Reasons/Rationale for selecting outcome measures

Cost savings can be demonstrated in a health care environment by assigning a monetary value to all aspects of a health care system. The monetary value depends on the direct or indirect cost of health care. Cost benefit analysis is used to summarize the cost and benefits of programs in a health care system to establish if it is effective in providing quality care delivery to the patient. The costs and benefits are usually monitored over time and need to be adjusted to the same time frame for the analysis. This type of analysis has been widely applied within the health care industry. One example is the potential savings of effectively implementing an electronic medical record (EMR) system[337] (1). The cost of a project is important to understand the risk of continuing to support a program in a health care system.

According to the Affordable Care Act (2010) the fee-for service model is changing to a pay per-performance model. The focus of reimbursement from the federal government is on the quality of the care rendered by a health care professional and not the number of services performed. The episode cost of care is a specific measure of the cost and utilization of health care. The cost is summarized for all of the health care services for a patient's medical condition within a defined period of time. This measure is vital to evaluate the entire experience of the patient in the health care system and rate the quality of care by the health professional.

Relationship to other Projects

This project is an element of the care continuum that Parkland will address through the waiver. Currently, patients stay in the hospital longer than necessary because there is no post-acute service available for them – most especially if they are indigent/Medicaid recipients.

[337] Hillestad, Richard, Bigelow, James, Bower, Anthony, Girosi, Federico, Meili, Robin, Scoville, Richard, Taylor, Roger. "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Cost." Health Affairs. September 2005. Vol 24. No 5. pp. 1103-1117.

This project relates to 127295703.2.9 (Care Transitions) and 127295703.2.7 (Patient Navigation)

Category 4 Related Outcomes

NA

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

There are no related projects being submitted in RHP 9.

Parkland plans to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to this project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. Parkland will also participate in any Outcomes Learning Collaborative that is associated with project outcomes to obtain additional perspectives that may enable improvement of the project. The exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance this project's success.

Project Valuation

Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 8.2 on a scale of 9.0. Factors that influenced this score included:

- The transformational impact this project can have on the pilot post-acute continuum assessment and the institutionalized methods the Parkland system will use ongoing to assure the greatest system benefits are derived from investment of its scarce resources
- Cost avoidance by improving the effectiveness assessment methodologies used
- Better alignment of Parkland system capacity with the needs of the community it serves
- Improving the Parkland system financial and operational sustainability

This project provides a basis for evaluating the cost effectiveness of proposed changes to the care continuum with the aim to inform decision making through the objective lens of system-wide and episode of care costs impact. With annual direct medical costs of $1.07 billion, every 1% cost saving that is achieved would yield an annual value of $10.1 million.

This project provides an infrastructural redesign that will yield immediate and sustained value for the system and the population it serves. Because the Parkland system serves a direct and proportionally growing population that is between two and four times the system's physical

and financial capacity, it is imperative to put in place a comprehensive, rigorous and proven methodology to assess every potential expansion or contraction of the system's care continuum. Once designed, piloted and refined, this methodology and associated tools will provide the basis for strong economic analysis to inform decision-making and the basis for verifying post-implementation effectiveness.

Unique Identifier: *127295703.2.5*	***Project Option:*** *2.5.2*	***Project Components:*** *NA*	***Title:*** *Design and Assess Cost Effectiveness of Post-Acute Care Alternatives*
Parkland Health & Hospital System			*127295703*
Related Category 3	*127295703.3.25*	*3.IT-5.1*	*-Improved cost savings*
Outcome Measure(s):	*127295703.3.26*	*3.IT-5.2*	*-Per episode cost of care*

Year 2 (10/1/2012 – 9/30/2013)	**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 cost-accounting methodology to quantify financial impact of quality/efficiency improvement interventions. Metric 1 [P-1.1]:Cost-accounting methodology Goal: Establish standardized method to evaluate the impact of continuum of care intervention alternatives. Data Source: Documentation of adopted methodology and plan for standardized use. Milestone 2 Estimated Incentive Payment (*maximum amount)*: $7,593,621	**Milestone 2** [P-3]: Implement the cost-accounting methodology and related systems to measure intervention impacts Metric 2 [P-3.1]: Cost-accounting system Goal: Fully implement cost accounting system module of existing decision support system Data Source: Cost accounting module implementation plan Milestone 1 Estimated Incentive Payment (*maximum amount)*: $1,941,617 **Milestone 3** [P-2]: Establish baseline for cost Metric 3 [P-2.1]: Establish baseline for cost Goal: Baseline cost used for comparison with post-acute continuum of care alternatives Data Source: Cost-accounting system in conjunction with financial and clinical data sets	**Milestone 6** [I-7]: Measure cost containment by re-measuring healthcare costs of an intervention and compare to baseline to gauge improvements in cost. Metric 7 [I-7.1]: Ratio of Post-Intervention Care Delivery to Baseline Goal: Produce a Ratio of Less than 1.0 Data Source: Cost-accounting system in conjunction with financial and clinical data sets Milestone 6 Estimated Incentive Payment: $3,877,213 **Milestone 7** [P-5]: Train finance staff on costing methodologies and define, develop, document methodologies with departments for allocation of costs to specific services Metric 8 [P-5.1]: Staff trainings and department specific methodologies – submission of training and department documents Goal: To assure consistent	**Milestone 8** [I-11]: Improvements in cost containment using innovative project option. Metric 9 [I-11.1]: Total cost per member of the population per month Goal: To produce the described metric as a resource to other stakeholders and for comparison to national benchmarks Data Source: Cost-accounting system in conjunction with financial and clinical data sets Metric 10 [I-11.2]: Hospital and ED utilization rates per episode cost of care Goal: Produce described metric as resource to other stakeholders and for comparison to national benchmarks Data Source: Cost-accounting system in conjunction with financial and clinical data sets Milestone 9 Estimated Incentive Payment: $6,261,339

Unique Identifier: *127295703.2.5*	***Project Option:*** *2.5.2*	***Project Components:*** *NA*	***Title:*** *Design and Assess Cost Effectiveness of Post-Acute Care Alternatives*
Parkland Health & Hospital System			*127295703*
Related Category 3	*127295703.3.25*	*3.IT-5.1*	*-Improved cost savings*
Outcome Measure(s):	*127295703.3.26*	*3.IT-5.2*	*-Per episode cost of care*

Year 2 (10/1/2012 – 9/30/2013)	**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: $1,941,617 **<u>Milestone 4</u>** [P-4]: Conduct cost analysis <u>Metric 4</u> [P-4.1]: Cost analysis or results – submission of cost analysis plan or results Goal: Apply methodology established in Milestone 2 to post-continuum of care design alternatives to inform investment decision Data Source: Care design alternatives; Cost analysis report(s) Milestone 4 Estimated Incentive Payment: $1,941,617 **<u>Milestone 5</u>** [P-7] Participate in interactions with other providers and RHP to promote collaborative learning around similar projects <u>Metric 5</u> [P-7.1.] Number of meetings, conference calls, or webinars Data Source: Documentation	application of cost accounting methodologies and standardize approach to intervention assessments Data Source: Training materials, meeting minutes, cost-accounting system or another administrative, financial or clinical data set Milestone 7 Estimated Incentive Payment: $3,877,214	

Unique Identifier: *127295703.2.5*	***Project Option:*** *2.5.2*	***Project Components:*** *NA*	***Title:*** *Design and Assess Cost Effectiveness of Post-Acute Care Alternatives*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measure(s):	*127295703.3.25* *127295703.3.26*	*3.IT-5.1* *3.IT-5.2*	*-Improved cost savings* *-Per episode cost of care*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Metric 6 [P-7.2] Share Challenges and solutions Data Source: Documentation Milestone 5 Estimated Incentive Payment (max amount): $1,941,617		
Year 2 Estimated Milestone Bundle Amount: $7,593,621	Year 3 Estimated Milestone Bundle Amount: $7,766,468	Year 4 Estimated Milestone Bundle Amount: $7,754,427	Year 5 Estimated Milestone Bundle Amount: $6,261,339
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):*			**$29,375,855**

Project Option 2.8.5 – Apply Process Improvement Methodology to Improve Quality/ Efficiency for Potentially Preventable Complications

Unique Project ID: 127295703.2.6

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare, and 7% Commercial Insurance.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY 2012 Volumes	Share of Dallas County Adults	
		Total	Medicaid/ Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Health Center	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Intervention: Led by physicians, this intervention will focus on implementing prevention strategies for potentially preventable complications. All patients will be screened and those at high risk for developing sepsis or other infections will be identified using an electronic clinical decision support system, PIECES, that works in conjunction with the electronic medical record (EMR) in real time. This model will trigger alerts to decrease time to interventions (antibiotic administration) to improve patient outcomes. The intervention will also include significant training/education of medical staff, residents, students, nurses and other clinicians regarding process improvements for potentially preventable complications.

Need for the Project: In addition to improved clinical outcome for high risk patients, this project will reduce the number of preventable complications, and sepsis mortality rates

through early identification of those patients at high risk and immediate implementation of interventions.

This project is physician-led with a care team including other physicians, nurses and clinicians to that will implement a preventable complications program focusing on preventive measures.

Target Population: While all patients are included in preventive strategies around preventable complications, the target population focuses on those patients at high risk for infections. Parkland averages 35,000-38,000 admissions per year, 75% of which come through the ED. In FY2012, Parkland treated 1,131 patients with sepsis, of which 214 died. Another 350 patients were identified with central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI) and surgical site infections (SSI). The goal is to reduce sepsis mortality and CLABSI, CAUTI and SSI rates for Parkland patients.

Category 1 & 2 Expected Patient Benefits: Benefits include reduced sepsis mortality and reduced risk for potentially preventable complications through early identification of high risk patients. FY2012 rates for infection and sepsis mortality are as follows:

- CLABSI: 2.5 per 1,000 catheter days
- CAUTI: 5.1 per 1,000 catheter days
- SSI: 3.1% (49/1,565 cases)
- Sepsis Mortality: 19%

Category 3 Outcomes: The outcomes/goals for this project include:

OD-4: Potentially Preventable Complications and Acquired Conditions

- IT- 4.2: Central line-associated bloodstream Infection (CLABSI). Goal is 25% annual decrease in DY3, DY4, DY5 for Hospital-Onset CLABSI cases
- IT-4.3: Catheter-associated Urinary Tract Infection (CAUTI). Goal is 25% annual decrease in DY3, DY4, DY5 for Hospital-Onset CAUTI cases
- IT-4.4: Surgical Site Infections (SSI). Goal is 10% annual decrease per year - D3, DY4, DY5
- IT-4.8: Sepsis Mortality. Goal is to decrease sepsis rate by 5% annually in DY3, DY4, DY5

Project Description

Parkland Health & Hospital System physician leadership will implement evidence-based interventions – prevention strategies – that will improve the rates of potentially preventable complications such as CLABSI, CAUTI, SSI and Sepsis Mortality.

Physicians at Parkland are collaborating to develop protocol-driven approaches to reduce risk of potentially preventable complications. Physicians are beginning to develop comprehensive screening tools for early detection, implementing rapid response/code sepsis procedures and

educating staff about protocols for sepsis and other complications. Physicians in the ED and ICU are coming together in this effort to improve communication and discuss process gaps that may lead to increased rates of infections and complications for patients and to discuss interventions to insure patients will not be readmitted once discharged. It has been well documented that improving communication between the ED and the ICU providers is integral to improving outcomes for patients with risk of infections.[338] For this process improvement project to be successful, access to real time data for the identification of patients who are at risk or who may be in the early stages of sepsis or at risk for having other complications is essential. Physicians have submitted a 5-year plan with prevention strategies to meet annual reductions in preventable CLABSI, CAUTI, SSI rates and sepsis mortality.

Goals and Relationship to Regional Goals

Parkland's goals for the project include providing earlier detection and improved quality of care for patients with sepsis/infections/other complications with the stated outcome of a reduction in potentially preventable complication rates - CLABSI, CAUTI, SSI and Sepsis. And once patients are treated and discharged, it is anticipated that unnecessary readmissions will be avoided.

Regional goals include improved provider performance and outcomes based on the Community Needs Assessment, where patient safety and quality were identified priorities.

Challenges

A quality improvement project to reduce complication rates poses some challenges to Parkland. Providers need access to real time data highlighting patients who may be at risk and those displaying early symptoms. There must be increased communication between physicians and at all sites of inpatient care including the ED and ICU and there must be more training/education regarding maintenance of catheters, hand hygiene, etc. for providers an increased education for patients being discharged with central venous catheters in care/maintenance. These challenges are being addressed through care teams who are committed to improving preventable complication rates.

5-Year Expected Outcome for Provider and Patients

The five year goal for the project is a reduction in complication rates (CLABSI, CAUTI, SSI) and sepsis mortality as a result of implementing early detection and prevention strategies and process improvement initiatives. This will not improve patient outcomes and reduce lengths of stay for those patients, providing bed access to other patients.

<u>Startimg Point/Baseline</u>

[338] STOP Sepsis Collaborative

In FY2012 at Parkland 1,131 patients were treated for sepsis of which 214 died. Additionally, more than 350 patients had CLABSI, CAUTI or SSI. The the incidence for Hospital-Onset infections in the ICU was as follows:

- CLABSI: 2.5 per 1,000 catheter days
- CAUTI: 5.1 per 1,000 catheter days
- SSI: 3.1% (49/1,565 cases)
- Sepsis Mortality: 19%

Rationale

Hospital acquired infections are a costly component of health care and in many cases are preventable. Urinary tract infections are the most common type of healthcare-associated infections and account for 30% of reported hospital-associated infections. Virtually all healthcare-associated urinary-tract infections (UTIs) are caused by insertion of catheters and as such CAUTI has been associated with increased morbidity, mortality, hospital cost, and length of stay, all of which lead to increased and redundant use of resources and increased costs.[339] Central line-Associated Bloodstream Infections (CLABSI) cause increased morbidity as well as mortality rates between 12% and 25%. Additional required resources and extended lengths of stay increase the costs of such preventable complications. Estimated costs per CLABS infection are approximately $25,000. [340] Surgical site infections (SSIs) are the most common type of nosocomial infections and lead to revision surgeries, delayed healing, increased use of medicine/antibiotics, and increased lengths of stay.[341]

Mortality rates from severe sepsis are on a similar scale to lung, breast, and colon cancer, and it is one of the leading causes of death in the intensive care unit as well as the tenth leading cause of death in the United States. Due to its aggressive, multifactorial nature, sepsis is a rapid killer. Death is common among sepsis patients, with around 30% of patients dying within the first month of diagnosis and 50% dying within 6 months (4-6). The 28-day mortality rate in sepsis patients is comparable to the 1960s hospital mortality rate for AMI patients.

Moreover, the number of severe sepsis cases is set to grow at a rate of 1.5% per year, adding an additional 1 million cases per year in the USA alone by 2020. This will increase total mortality and increase the burden on health care resources. The increase is mainly due to the growing use of invasive procedures and increasing numbers of elderly and high-risk individuals, such as cancer and HIV patients. Older people are at an increased risk of sepsis as they are more

[339] Centers for Disease Control. http://www.cdc.gov/hicpac/CAUTI_fastFacts.html. 2012.
[340] Posa, Patricia; Harrison, Denise; Vollman, Kathleen; Ackerman, Michael H. "Elimination of Central Line-associated Bloodstream Infections: Application of the Evidence". AACN Advanced Critical Care. Oct/Dec 2006 – Vol 17 (4). p 446–454
[341] Harrop JS, Styliaras JC, Ooi YC, Radcliff KE, Vaccaro AR, Wu C. "Contributing Factors to Surgical Site Infections." J AM Academy of Orthopedic Surgery. 012 Feb;20(2):94-101

vulnerable to infections due to aging, co-morbidities, use of invasive surgical techniques, and problems associated with institutionalization. [342]

According to the STOP Sepsis campaign, sepsis costs hospitals across the nation $16.7 billion annually. It can result in increased hospital stays as well as increases in utilization in the ED and ICUs, the most expensive sites to deliver care. There is evidence that the costs associated with sepsis patients in an ICU are six times higher than ICU patients without sepsis[343].

Based on the recent report by the Texas Health and Human Services Commission "Potentially Preventable Complications in the Texas Medicaid Population," there were more than 21,000 potentially preventable complications (PPC) in Texas hospitals in State Fiscal Year 2011 at an estimated hospital cost of $88.7 million.[344] In attempts to address these potentially preventable complications, hospitals and physicians are implementing interventions to identify patients at risk for acquiring infections and to detect early signs of infections in order to treat quickly and effectively.

Project Components

There are no required core components for this Project Option.

Milestones and Metrics

- P-1: Target specific workflows, processes and/or clinical areas to improve
    - P-1.1: Performing provider review and prioritization of areas or processes to improve upon
- P-6: Implement program to improve efficiencies and/or reduce program variation
    - P-6.1: PI Events
- P-8: Train providers/ staff in process improvement
    - P-8.1: Number trained
- P-13: Participate in at least biweekly interactions (meetings, calls, webinars) with other providers and RHP to promote collaborative learning around shared or similar ideas
    - P-13.1: Number of biweekly meetings, calls, webinars organized by RHP that provider participated in
- P-X: Engage clinicians, non-clinicians and other stakeholders in developing interventions
    - P-X.1: Engage stakeholders, identify resources, potential partnerships, develop intervention plan (implementation, evaluation, sustainability)
- I-16: Improve quality and efficiency using innovative project option

[342] http://www.survivingsepsis.org/About_the_Campaign/Pages/AbouttheCampaign.aspx

[343] Edbrooke DL, HIbbert CL, Kingsley JM, Smith S. Bright NM, Quinn JM (1999) the patient-related cost of care for sepsis patients in a United Kingdom adult general intensive care unit. Crit Care Med 27: 1760-1767.

[344] Texas Health & Human Services Commission. "Potentially Preventable Complications in the Texas Medicaid Population." Public Report. November 2012.

- I-16.2: Improved clinical indicators

Unique Community Need Identification Numbers the Project Addresses

- *CN.11: Patient Safety and Quality*

How the Project significantly enhances an existing delivery system reform initiative

The focus of this quality improvement project is the improvement of quality of care for patients at risk for complications/infections through implementation of planned interventions developed by physicians at Parkland.

The project has no related activities funded by U.S. Department of Health & Human Services.

Related Category 3 Outcome Measure(s)

OD-4: Potentially Preventable Complications and Healthcare Acquired Conditions

- IT-4.2: Central line-associated bloodstream infections (CLABSI) (Standalone Measure)
- IT-4.3: Catheter-associated Urinary Tract Infections (CAUTI) (Standalone Measure)
- IT-4.4: Surgical Site Infections (SSI) (Standalone Measure)
- IT-4.8: Sepsis Mortality (Standalone Measure)

Infections cause delayed healing, increased pain and discomfort for patients, and additional days in the hospital, potential readmissions and increased morbidity and mortality. Best practice and evidence-based protocols contribute to the reduction of the number of infections, improving patient outcomes, and increasing hospital capacity for other patients. We are implementing an evidence-based program for early identification of patients at high risk for infections. Earlier identification will trigger alerts to begin certain interventions that will reduce the risk of acquiring infections or sepsis. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through the physician care teams.

Relationship to Other Projects

This project's milestone metrics and clinical outcomes will be leveraged with work being done in Project 127295703.1.4 - Enhance Performance Improvement and Reporting Capacity.

Category 4 Related Outcomes

- RD-3: Potentially Preventable Complications

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

While no other projects have been submitted specific to CLABSI, CAUTI and SSI, several projects have been submitted for sepsis management and include the following:

Performing Provider	Unique Project
Denton Regional Medical Center (HCA)	111905902.2.1
Medical City of Dallas Hospital (HCA)	020943901.2.2
Medical Center of Lewisville (HCA)	094192402.2.2

We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to this project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. Parkland will also participate in any Outcomes Learning Collaborative that is associated with project outcomes to obtain additional perspectives that may enable improvement of the project. The exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance this project's success.

Project Valuation

Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 8.7 on a 9.0 scale. Influencing factors included:

- By implementing process improvement methodologies and evidence-based interventions, complications such as CLABSI, CAUTI and SSI can be significantly reduced
- By implementing interventions to reduce infection rates, costs will be avoided/reduced
- Sustainable improvement of clinical outcomes for patients

When considering institutional cost avoidance, excess utilization of scarce resources such as ICU and inpatient beds, and the value of lives saved through the reduction of the number of CLABSI, CAUTI and SSI cases, the value to the health care system and community is enormous. Considering a Value of Statistical Life of $7.9 million[345], the table below presents the impact this project is intended to have on sepsis mortality alone:

Waiver Year	Mortality Rate	Actual Cases of Mortality	Proforma Cases of Mortality	Proforma Reduction in Cases of Mortality	Proforma Estimate of Value
Baseline	14.4%	116			
DY4	13.7%		110	6	$47,400,000
DY5	13.0%		105	9	71,100,000
					$118,500,000

The pro forma value of $118.5 million compares favorably with the proposed total Categories 2 and 3 value of $39,192,393.

[345] U.S. Environmental Protection Agency – Value of Statistical Life

Unique Project: *127295703.2.6*	***Project Option:*** *2.8.5*	***Project Components:*** *NA*	***Title****: Apply Process Improvement Methodology to Improve Quality/ Efficiency for Potentially Preventable Complications*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.27* *127295703.3.28* *127295703.3.29* *127295703.3.44*	*3.IT-4.2* *3.IT-4.3* *3.IT-4.4* *3.IT-4.8*	*-Central Line-Associated Bloodstream Infection (CLABSI) Rate* *-Catheter-Associated Urinary Tract Infection (CAUTI) Rate* *-Surgical Site Infection (SSI) Rate* *- Sepsis Mortality Rate*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] 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 Goal: Submission of Provider report Data Source: Documentation of workflows, processes Milestone 1 Estimated Incentive Payment (max amount): $8,056,647	**Milestone 2** [P-6] Implement program to improve efficiencies and/or reduce program variation Metric 2 [P-6.1]: PI Events Goal: Identify targeted events Data Source: Analysis of PI documentation of findings/ results Milestone 2 Estimated Incentive Payment (max amount): $2,060,008 **Milestone 3** [P-8]: Train providers/ staff in process improvement Metric 3 [P-8.1]: Number trained Goal: Establish training module for all employees/residents/medical staff/ students (6,600 total) Data Source: Training module with report of number of staff who completed training/education Milestone 3 Estimated Incentive Payment (max amount): $2,060,008	**Milestone 6** [I-16] Improve quality and efficiency using innovative project option Metric 6 [I-16.2]: Improved clinical indicators Goal: 85% adherence to use of IHI Bundles of Care for CLABSI, CAUTI Goal: 80% adherence to use IHI Bundles of Care for SSI for all procedures Goal: 90% adherence to protocols using early goal-directed therapy for sepsis Data Source: Record audits Milestone 6 Estimated Incentive Payment (max amount): $8,227,258	**Milestone 7** [I-16] Improve quality and efficiency using innovative project option Metric 7 [I-16.2]: Improved clinical indicators Goal: 95% adherence to use of IHI Bundles of Care for CLABSI, CAUTI Goal: 90% adherence to use IHI Bundles of Care for SSI for all procedures Goal: 100% adherence to protocols using early goal-directed therapy for sepsis Data Source: Record audits Milestone 7 Estimated Incentive Payment (max amount): $6,643,128

Unique Project: *127295703.2.6*	***Project Option:*** *2.8.5*	***Project Components:*** *NA*	***Title****: Apply Process Improvement Methodology to Improve Quality/ Efficiency for Potentially Preventable Complications*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.27* *127295703.3.28* *127295703.3.29* *127295703.3.44*	*3.IT-4.2* *3.IT-4.3* *3.IT-4.4* *3.IT-4.8*	*-Central Line-Associated Bloodstream Infection (CLABSI) Rate* *-Catheter-Associated Urinary Tract Infection (CAUTI) Rate* *-Surgical Site Infection (SSI) Rate* *- Sepsis Mortality 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)**
	<u>Milestone 4</u> [P-13] Participate in at least biweekly interactions (meetings, calls, webinars) with other providers and RHP to promote collaborative learning around shared or similar ideas <u>Metric 4</u> [P-13.1] Number of biweekly meetings, calls, webinars organized by RHP that provider participated in Goal: Participation in collaboratives Data Source: Documentation of meetings, calls, webinars attended Milestone 4 Estimated Incentive Payment (max amount): $2,060,008 **<u>Milestone 5</u>** [P-X] Engage clinicians, non-clinicians and other stakeholders in developing interventions <u>Metric 5</u> [P-X.1] Engage stakeholders, identify resources, potential partnerships, develop intervention plan (implementation, evaluation,		

Unique Project: *127295703.2.6*	***Project Option:*** *2.8.5*	***Project Components:*** *NA*	***Title****: Apply Process Improvement Methodology to Improve Quality/ Efficiency for Potentially Preventable Complications*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.27* *127295703.3.28* *127295703.3.29* *127295703.3.44*	*3.IT-4.2* *3.IT-4.3* *3.IT-4.4* *3.IT-4.8*	*-Central Line-Associated Bloodstream Infection (CLABSI) Rate* *-Catheter-Associated Urinary Tract Infection (CAUTI) Rate* *-Surgical Site Infection (SSI) Rate* *- Sepsis Mortality 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)**
	sustainability) Goal: Complete intervention plans Data Source: Plan documentation Milestone 5 Estimated Incentive Payment (max amount): $2,060,009		
Year 2 Estimated Milestone Bundle Amount: $8,056,647	**Year 3 Estimated Milestone Bundle Amount:** $8,240,033	**Year 4 Estimated Milestone Bundle Amount:** $8,227,258	**Year 5 Estimated Milestone Bundle Amount:** $6,643,128
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):*			**$31,167,066**

Project Option 2.9.1 – Enhance Patient Navigation

Unique Project Identifier: 127295703.2.7

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare and 7% Commercial Insurance.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY 2012 Volumes	Share of Dallas County Adults	
		Total	Medicaid/Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Health Center	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Intervention:

Develop and implement a new patient navigation program to provide support and assistance with connections to care for Parkland patients with mental health disorders that present in the emergency department or at community health clinics. Unlike the more clinically-oriented nurse navigators supporting other Parkland medical, surgical and chronic disease patient cohorts, the competencies for this navigator role will emphasize cultural and language competence and focus more on connecting patients to resources and support systems, addressing health and social barriers, facilitating communication, streamlining appointments and paperwork, implementing outreach strategies and supporting patient activation and self-management.

Need for the Project:

People with serious mental illness suffer excess mortality and die on average 25 years earlier, compared to the general population. An estimated 60% of those with serious mental illness die from preventable diseases. There is an increasing need for resources that can support this patient population and assist with their connections to medical and mental health care.

Annually, an approximate 14,000 unique individuals have approximately 30,000 encounters in the Parkland system with a primary diagnosis of mental disorder. The use of this criteria provides a conservative view of the Parkland patient population with mental illness, but provides context as a basis for evaluation.

This described patient set accounts for approximately 100,000 Parkland encounters with any primary diagnosis. Of this patient set, within a year, 5 patients had more than 40 ED encounters, 25 had between 20 and 40 ED encounters, 100 had between 10 and 20 ED encounters and 250 had more than 5 ED encounters. Of this patient set, approximately 45% had a payer status of Self Pay or Charity, 30% were Medicaid and approximately 20% were Medicare.

Improved care navigation support and assistance to this sizable and vulnerable population would yield improved use of health care resources and better health status outcomes for the individuals. Further, because mental health resources are in particularly high demand, focused patient navigation support is necessary to assure appropriate care coordination occurs and individual needs are prioritized and met.

Target Population: The patients targeted for this intervention will include patients with a mental disorder primary diagnoses with an encounter primarily in the Parkland emergency department (potentially post-discharge if admitted from the ED), provider referrals from the community and campus-based primary care providers for patients with primary or co-occurring mental disorder diagnoses who are determined to require or could substantially benefit from navigation support, and referrals through Parkland system case managers and discharge planners. This intervention will target Medicaid and indigent patients.

Category 1 & 2 Expected Patient Benefits: Benefits include improved patient outcomes including decreased unnecessary ED visits/readmissions, increased access to needed care, and enhanced self-management skills as well as increased patient and family satisfaction.

Category 3 Outcomes: The FY16 goals include the following improved outcomes:

- IT.3.1: All Cause 30-day Readmission Rate
    - Goal: Decrease readmissions rate from 8.74% (2,770/31,683) to 8.5%

Project Description

Parkland will develop and implement a new patient navigation program to provide support and assistance with connections to care for Parkland patients with mental health disorders that present in the emergency department or at community health clinics.

This intervention will extend the existing Care Management program by designing and implementing a new Patient Navigation program to provide support to patients with serious mental illness who present in Parkland's emergency department and community health centers. The project will consist of three phases: program design and development, program pilot and implementation, post-implementation assessment.

Program Design and Development

Three nurse navigation programs currently exist at Parkland supporting patients in oncology, trauma and surgical services. While these programs support connecting patients to appropriate clinical resources, they are clinically focused to assist patients with complex medical needs within the Parkland system. As conceived, this new navigation program will be less clinically oriented and focus more on a range of navigation needs specific to this targeted patient population, connecting resources within and outside the Parkland system.

Because the target population for this program may require access to both behavioral health and medical resources, may require connection to services inside and outside the Parkland system, may confront multiple financial eligibility determinations, and may have more direct need for cultural and language competency, this new navigation program will require a dedicated focus and differentiated design.

The first step in the program design will be a needs assessment and demand analysis that will assess the number and the clinical and demographic characteristics of the target emergency department and community health center target populations. Eligibility criteria will be established and will consider age (age 18 or older), mental illness diagnosed disorder, medical condition(s), presence or absence of a regular primary care provider. It is anticipated that patients actively suicidal or homicidal will not be eligible. Patients who have been admitted to the hospital for stabilization will be screened for eligibility once stabilized and ready for discharge. With a refined understanding of the patient population size and characteristics, the eligibility thresholds will be determined for the pilot phase of the implementation.

On the basis of the initial program design, the role, characteristics and competencies of the patient navigator will be shaped. At this time, it is believed that the navigator competencies will weigh heavily toward cultural and language competency, conversancy with the internal and external health and community resources and financial eligibility systems – favoring a health care worker profile. A navigator workload will be estimated for testing through the pilot phase.

Program Pilot and Implementation

On completion of the initial program design, eligibility criteria and navigator role determination, one or two pilot sites will be selected and a pilot program will be instituted and continued for a period of six weeks to six months. During the pilot, the program design, patient eligibility criteria and staffing model will be tested and refined. It is anticipated that during the pilot phase, approximately 200 patients will be enrolled - 50 patients through referral from the primary care setting, 50 patients referred by Case Management and 100 patients enrolled through the emergency department.

Based on the learnings from the pilot, the implementation design will be finalized and an implementation plan prepared to include: sites of care, space requirements, staffing, policies and procedures, health record calibration, training and orientation programs for program staff, internal resource staff and external resources, agencies and community partners and a post-implementation assessment design. Upon full implementation, it is anticipated that the program will serve approximately 3,500 unique individuals annually.

The program will be operationalized in accordance with the implementation plan. Throughout late pilot and implementation phases, the program team will participate in regional and statewide learning collaboratives, face-to-face learning and other performance improvement initiatives.

Post Implementation Assessment

A post implementation assessment will be a component of the implementation plan and will be conducted as indicated in the plan. The functional activities of the Care Transitions program will make use of system-wide performance improvement methods and practices.

Goals and Relationship to Regional Goals

The patient navigator program will insure patients with mental disorders are directed to the appropriate care setting within or outside the health system. With teams interacting with patients, identifying gaps and barriers to services, insuring good communication and planning for the next steps in the patient's care, the percentage of high utilizers of ED services and readmissions should decline.

Regional goals include improved access to care, improved care coordination and improved provider performance and outcomes. A best-practice care coordination program at Parkland supports all goals by improving access to appropriate care settings and coordinating care for the patient across the care continuum. Patient navigators are instrumental in assisting patients and insuring care is managed appropriately in the appropriate care settings.

Challenges

As a new initiative, it will be imperative to establish and use clear protocols to identify and enroll targeted patients in the Navigation program. It will also be necessary to establish clear interfaces between this program and base Care Management and associated programs so as to best invest and direct the resources of the Navigation Program. Again as a new initiative, focused attention must be paid during implementation to measure and modify, as appropriate, the intervention design to assure that the desired outcomes are achieved.

5-Year Expected Outcome for Provider and Patients[346]

The patient navigator program is intended to enhance efficiency and patient flow/throughput and also establish closer linkages between hospital respective community organizations and services. Specifically for patients, the 5-year expected outcome will be a decrease in the number of All Cause and Diabetes 30-day Readmission Rates and a decrease in the number of patients targeted by this intervention with ED visits within 30 days of discharge.

Starting Point/Baseline

A conservative estimate of the population pool for this initiative is approximately 14,000 unique patients. Because this will be a new navigation program, no patients are currently enrolled.

Rationale

Care coordination programs, and specifically patient navigation programs, have been proven to improve providers' ability to track, manage, and support patient care, while simultaneously improving provider/patient communication and trust among disadvantaged populations.[347] Such programs have emerged as a means of coordinating fragmented care, identifying gaps in care, and facilitating patient access to appropriate follow-up care settings.

Specific to Parkland's patient navigation program, the goal is to improve access to care for patients with mental disorders who are discharged from the hospital and/or ED or referred by primary care providers and care management professionals. The program will educate patients on accessing and utilizing health care services and will empower patients with knowledge they need in their next steps of treatment. Patient navigators work with patients and provide patients with confidence about their treatment plan which will likely improve patients' compliance rate with follow up.

Enhanced utilization of patient navigation services is intended to prevent readmissions and decrease unnecessary ED visits. ED use for non-emergency care and repeat use for unresolved conditions is not desirable for the hospital or the patient. Episodic ED care lacks the benefits from the continuity of care and is costly to provide in the acute resource setting of the hospital

[346] Clinical Intelligence. "Leveraging Parkland's Interdisciplinary Care Coordination Teams Across the Healthcare Continuum-Care Coordination Redesign." September 5, 2012.

[347] Dohan D. & Schrag D. Using Navigators to Improve Care of Underserved Patients: Current Practices and Approaches. *American Cancer Society*. 2005. Pp. 848-855. Published online 11 July 2005 in Wiley InterScience.

ED. Nevertheless, hospitals continue to struggle with providing care to increasing numbers of vulnerable adults who use them as their primary source of health care.

Project Components

The required core components of this project - 2.9.1 are as follows:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency. *The needs assessment and demand analysis will support the development of eligibility requirements and highlight the particular needs for cultural competency training*.
b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators*. As the program design is developed, the specific role and skill set of the navigators will be determined*.
c) Connect patients to primary and preventive care. *The project design supports connections to primary care and to appropriate community support services and resources*.
d) Increase access to care management and/or chronic care management, including education in chronic disease self-management. *Goals of the care coordination program redesign is to insure patients can identify their navigator, participate in care decisions, have coordinated community support and are satisfied with access and care coordination.*[348]
e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. *A variety of methods and techniques will be used throughout project design, piloting, implementation and post-implementation to maximize the effectiveness of this intervention.*

Project Milestones and Metrics

- P-1: Conduct needs assessment to identify targeted patient population
    - P-1.1: Report identifying patient population at high risk of readmissions:

[348] Clinical Intelligence. "Leveraging Parkland's Interdisciplinary Care Coordination Teams Across the Healthcare Continuum-Care Coordination Redesign." September 5, 2012.

- P-2: Expand health care navigation program to provide support to patient populations who are most at risk of receiving disconnected/fragmented care including training programs, procedures, continuing education
    - P-2.1: Number of people trained as patient navigators, number of navigation procedures, number of CE sessions for navigators
    - P-2.2: Number of unique patients enrolled in program
- P-8: Participate in face-to-face learning at least twice per year with other providers and RHP to promote collaborative learning around shared or similar projects
    - P-8.1: Participate in semi-annual face-to-face meetings or seminars
    - P-8.2: Implement "raise the floor" improvement initiatives from meetings
- I-8: Reduction in ED use by identified ED frequent users receiving navigation services
    - I-8.1: ED visits pre- & post- navigation services by individuals ED frequent users

Unique Community Need Identification Numbers the Project Addresses

- Lack of access to primary care (CN.4), behavioral care (CN.5), and specialty care (CN.8)
- Emergency Department utilization and Readmissions (CN.12)

Related Category 3 Outcome Measure(s)

OD-3: Potentially Preventable Admissions

- IT.3.1: All Cause 30-day Readmission Rate (Stand-alone Measure)

Communication barriers can influence the risk of admissions and readmissions for patients with mental health issues. Patients in the ED and/or hospital need to understand their discharge instructions for recovery or for transfer to another facility. Patients with mental health issues require additional attention – they may not understand instructions or it may not be well communicated. Better communication can assist in preventing a mental health care issue from becoming more serious and requiring hospitalization. In particular, the degree to which staff members communicate with patients about their discharge needs can directly impact the risk of readmission for patients. Patient navigators can provide the extra attention necessary and offer assistance in transferring patients to other settings where they can receive appropriate care. Readmissions will provide a measure to inform whether the communication and navigation assistance is successful for these patients.

Relationship to Other Projects

As key components of the care coordination redesign, patient navigation and care transitions are interrelated. Other projects are interrelated since they are components of the care delivery system that will support patient navigation and care transitions. Those projects are as follows:

Unique Project	Option	Project Description
127295703.1.1	1.1.2	Expand existing primary care capacity – Grand Prairie

127295703.1.2	1.1.2	Expand existing primary care capacity
127295703.1.6	1.1.1	Establish more primary care clinics – Acute Response Clinic
127295703.2.1	2.1.1	Expand/enhance medical home model
127295703.2.10	2.1.1	Expand/enhance medical home model – Family Medicine
127295703.2.5	2.5.2	Assess cost effectiveness of post-acute care alternatives
127295703.2.9	2.12.1	Implement care transitions program

Category 4 Related Outcomes

- RD-2: Potentially Preventable Readmissions for All Cause and Diabetes
- RD-5: Emergency Department

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

Related projects (Project Option 2.9) that performing providers are submitting include:

Performing Provider	Unique Project
Baylor Medical Center at Garland	121790303.2.4
Baylor Medical Center at Irving	121776204.2.4
Baylor University Medical Center	139485012.2.3
Children's Medical Center	138910807.2.3
Medical Center of Lewisville (HCA)	094192402.2.3
Methodist Charlton Medical Center	126679303.2.2
Methodist Dallas Medical Center	135032405.2.3
Methodist Richardson Medical Center	209345201.2.2
Texas Health Presbyterian – Denton	020967801.2.1
Texas Health Presbyterian – Kaufman	094140302.2.1
UT Southwestern – Faculty Practice Plan	126686802.2.4
UT Southwestern – University Hospital	175287501.2.2

It is anticipated that this project will dovetail specifically with the Dallas County project 121758005.1.1 – Development of Behavioral Health Crisis Stabilization Services as Alternatives to Hospitalization. This project is designed to provide new behavioral health services and targets, in part, patients from Parkland's emergency department and community health centers.

We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to this project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. Parkland will also participate in any Outcomes Learning Collaborative that is associated with project outcomes to obtain additional perspectives that may enable improvement of the project. The exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance this project's success.

Project Valuation

Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 6.20 on a 9.0 scale. Influencing factors included:

- The strong impact this will have with respect to managing, at the health system level, patients among Parkland's vulnerable population at highest risk for complex/ costly care
- Cost avoidance by providing streamlining and enabling program patients to obtain the right care in the right place at the right time
- Patients with behavioral health disorders are among the region's most vulnerable patient population. Access to behavioral health resources is challenging; without intervention, the emergency department and criminal justice system become the most accessible and most costly alternatives.

In the two post-implementation years of the plan, this project will impact the lives of 6,000 individuals, assisting them to access the resources they require for their physical and mental health. This will promote greater economic productivity as well as reducing the costs of medical and behavioral care.

There are opportunities for partnership and collaboration with the many performing providers in RHP 9 that are pursuing patient navigation projects

Unique Project: *127295703.2.7*	***Project Option:*** *2.9.1*	***Project Components:*** *2.9.1 (a-e)*	***Title:*** *Enhance Patient Navigation Program*
Parkland Health & Hospital System			***127295703***
Related Category 3 Outcome Measures:	*127295703.3.30* ~~*127295703.3.31*~~ ~~*127295703.3.32*~~	*3.IT-3.1* ~~*3-IT-3.3*~~ ~~*3-IT-9.2*~~	*-All Cause 30 Day Readmission Rate* ~~*-Diabetes 30 Day Readmission Rate*~~ ~~*-ED Appropriate Utilization*~~

Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014-9/30/2015)**	**Year 5 (10/1/2015-9/30/2016)**
Milestone 1 [P-1] Conduct needs assessment to identify targeted patient population Metric 1 [P-1.1]: Report identifying patient population at high risk of readmissions: -Targeted patient population characteristics -Gaps in services and service needs How program will identify, triage and manage target population -Number of Patient Navigators needed -Available site, state, county and clinical data including cases by race/ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients	**Milestone 2** [P-2] Expand health care navigation program to provide support to patient populations who are most at risk of receiving disconnected/ fragmented care including training programs, procedures, continuing education Metric 2 [P-2.1]: Number of people trained as patient navigators, number of navigation procedures, number of CE sessions for navigators Baseline: New program, no navigators Goal: Recruit and train 2 navigators to conduct pilot Data Source: HR Documentation of recruitment; documentation of training Metric 3 [P-2.2]: Number of unique patients enrolled in program Baseline: 0 patients Goal: Enroll 200 patients for pilot phase Data Source: EHR, report	**Milestone 4** [P-2] Expand health care navigation program to provide support to patient populations who are most at risk of receiving disconnected/ fragmented care including training programs, procedures, continuing education Metric 6 [P-2.2]: Number of unique patients enrolled in program Baseline: 0 patients Goal: Enroll 2,500 patients in DY4 Data Source: EHR, report **Milestone 5** [I-8] Reduction in ED use by identified ED frequent users receiving navigation services Metric 7 [I-8.1]: ED visits pre- and post- navigation services by individuals identified as ED frequent users Baseline: Unknown – no patients enrolled Goal: 20% reduction in ED visits pre- and post- navigation services by individuals identified as ED	**Milestone 6** [P-2] Expand health care navigation program to provide support to patient populations who are most at risk of receiving disconnected/ fragmented care including training programs, procedures, continuing education Metric 8 [P-2.2]: Number of unique patients enrolled in program Baseline: 0 patients Goal: Enroll 3,500 patients Data Source: EHR, report **Milestone 7** [I-8] Reduction in ED use by identified ED frequent users receiving navigation services Metric 9 [I-8.1]: ED visits pre- and post- navigation services by individuals identified as ED frequent users Baseline: Unknown – no patients enrolled Goal: 40% reduction in ED visits pre- and post- navigation services by individuals identified as ED

Unique Project: *127295703.2.7*	***Project Option:****2.9.1*	***Project Components:*** *2.9.1 (a-e)*	***Title:*** *Enhance Patient Navigation Program*
Parkland Health & Hospital System			***127295703***
Related Category 3 Outcome Measures:	*127295703.3.30* ~~*127295703.3.31*~~ ~~*127295703.3.32*~~	*3.IT-3.1* ~~*3 IT-3.3*~~ ~~*3 IT-9.2*~~	*-All Cause 30 Day Readmission Rate* ~~*-Diabetes 30 Day Readmission Rate*~~ ~~*-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)**
Goal: Produce needs assessment report Data Source: Documentation, EHR Milestone 1 Estimated Incentive Payment (max amount): $ 5,741,518	Milestone 2 Estimated Incentive Payment (max amount): $2,936,104 **<u>Milestone 3</u>** [P-8] Participate in face-to-face learning at least twice per year with other providers and RHP to promote collaborative learning around shared or similar projects. <u>Metric 4</u> [P-8.1] Participate in semi-annual face-to-face meetings or seminars <u>Metric 5</u> [P-8.2] Implement "raise the floor" improvement initiatives from meetings Data Source: Meeting documentation Milestone 3 Estimated Incentive Payment (max amount): $2,936,104	frequent users (5 or more visits in prior year) Data source: Program registry, EHR Milestone 5 Estimated Incentive Payment (max amount): $ 5,863,103	frequent users (5 or more visits in prior year) Data source: Program registry, EHR Milestone 5 Estimated Incentive Payment (max amount): $ 4,734,183
Year 2 Estimated Milestone Bundle Amount: $5,741,518	**Year 3 Estimated Milestone Bundle Amount:** $5,872,208	**Year 4 Estimated Milestone Bundle Amount:** $5,863,103	**Year 5 Estimated Milestone Bundle Amount:** $4,734,183
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)			$22,211,012

Project Option 2.10.1 – Use of Palliative Care Programs

RHP Project Identifier: 127295703.2.8

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare and 7% Commercial Insurance.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY2012 Volumes	Parkland Share of Dallas County Adults	
		% Market Share	Medicaid/ Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Centers	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Intervention: Parkland has a small inpatient consult palliative care service. This intervention will establish a comprehensive palliative care program including an enhanced outpatient clinic program and a dedicated inpatient unit. Currently approximately 40 inpatients are identified each day who require palliative care services and without a dedicated unit, the patients are spread throughout the hospital on the medical and surgical units. The comprehensive and dedicated palliative program will assure these patients are cared for in a comfortable environment by specially trained medical staff, nurses, social workers and care managers.

Need for the Project: In FY2012, there were 1,174 inpatients at Parkland identified as having a palliative care encounter (ICD-9-CM code V66.7 "Encounter for Palliative Care") while more than 7,000 patients were identified as potentially needing palliative care services. Currently and at any given time in the oncology program, there are 75 patients (80% indigent/Medicaid) waiting for palliative care consult services.

Of those who had Palliative care consults in FY2012, 150 had 1+ ED visits within 30 days of their death. While that number is relatively low in comparison to the total number of discharges, it is 12.7% of patients who did have palliative services. With expanded capacity of the Palliative program, the number of patients who utilize the ED could potentially rise without interventions in place to assure that does not happen.

Target Population: In FY2012, 1,174 inpatients at Parkland received palliative care consults and 210 died at Parkland, while more than 7,000 were identified as potentially requiring palliative care services. The target population includes all patients with life-limiting illnesses and their family/caregivers and of those, the goal is to insure they are discharged to an appropriate setting and do not have unnecessary medical services in the last days of their lives.

Category 1 & 2 Expected Patient Benefits: Expected benefits for palliative patients include improved satisfaction with their care. As inpatients, they would be within a dedicated palliative unit where staff members and patients around them share their fears/concerns and can provide support. And, as appropriate, they can be sent home or to other settings earlier where they and their families may be more comfortable. Outpatient services can be set up and tailored to their needs as well.

With care centered on each patient, providers and their care team of nurses and other clinicians and non-clinical team members (pastors, etc.), patients will be less likely to have unnecessary medical services near the end of their life. This will reduce their fear/anxiety as well as that of their families. Pain management and other compassionate type services can be provided and patients can focus on other end-of-life concerns.

Organizations may see a reduction in utilization high cost services at the end of life and also reduced length of stay for patients who are palliative scattered across the hospital which translates to lowered costs if patients are placed in a dedicated unit and discharged quicker to a more appropriate setting.

Category 3 Outcomes: Although there are other appropriate outcomes including improved patient and family experience for this trying time, the improved measurable outcome selected for this project includes:

OD-13: Palliative Care

- IT-13.3: Proportion of patients with more than one ER visit in the last days of life

- Goal: With increased palliative care capacity/volumes, the goal is to decrease the percentage of patients with more than 1 ER visit in the last days of life by 50%

Project Description

Parkland will implement a palliative care program based on an interdisciplinary palliative care model. A business plan will address inpatient and outpatient needs for palliative care for patients at Parkland and will follow an evidence-based care model as supported by the Center to Advance Palliative Care (CAPC) to insure implementation of a comprehensive program.

According to the Center to Advance Palliative Care (CAPC), palliative care programs "link diverse hospital departments and services for effective and efficient use of hospital resources. This approach results in higher quality, well-planned treatment that anticipates future care needs."

Currently Parkland inpatients who require palliative care are scattered throughout the medical/ surgical and ICU units within Parkland Hospital. Care is provided by many with good intent but with little or no experience/ education/ training regarding care for palliative patients. Faculty members provide palliative care through consult services in the hospital and feel that care could be provided more effectively in an identified inpatient unit. Additionally, there are not enough providers for the outpatient care needs as well for palliative patients.

Parkland will address the feasibility of implementing a palliative care program to address end-of-life decisions and care needs that patients may have. Specifically, this project will enable development of a business plan for palliative care including the planning activities necessary as precursor to implementing the program. Once the business plan is developed Parkland will transition palliative care patients from acute hospital care into a more appropriate setting such as home care, hospice or a skilled nursing facility. The plan for palliative care will address inpatient but also the outpatient setting to insure as capacity is expanded by establishing a palliative care unit, the balance for outpatient care capacity is also addressed.

Goals and Relationship to Regional Goals:

The goal of this project is to insure that patients who are eligible for palliative care services receive the best and most appropriate care in the most appropriate setting possible. Specifically, this project will direct planning, implementation and monitoring of improvements to ensure that palliative care for terminal patients occurs in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences. Project objectives include:

- Develop a business plan for palliative care which will determine the total need for services as well as space and staffing needs for palliative care and associated cost
- Establish a dedicated unit for palliative care patients
- Increase the number of palliative care consults

- Implement palliative care education and training programs for providers that incorporate management of non-cancer patients

Providing palliative care in an appropriate setting such as a palliative or hospice unit frees up much needed capacity in other units to accommodate patients who may be in the ER waiting for a bed. Not only does the unit provide a dignified and comfortable environment for patients with very specific end-of-life needs, it provides opportunity for the hospital to provide care to other patients who may have otherwise not had access. The new bed capacity allows more access and thus meets regional goals of increasing capacity to services.

Regional goals include improved access to care, improved care coordination and management and improved provider performance and outcomes. Providing palliative care in a focused manner provides access to better care and also allows improved care management for this population and their families.

Challenges

Palliative care is a medical model arising from the prolonged life issues resulting from medical technology advances. It focuses on quality of life rather than curing disease or prolonging life in terminal situations. As such, there is growing acknowledgment that the end-of-life experience is an important factor in treatment and health care decisions. This involves teaching, counseling, coordinating, monitoring, and assisting patients to gain access to needed care, medications, and services.

Because of the breadth of palliative care needs, a variety of professionals and services are required for full availability to patients. Further, the relative newness of palliative care as a medical specialty limits the number of medical professionals available to provide that care. Thus, the biggest challenge to this project will be arraying and facilitating collaboration among the variety of professionals and service providers needed to effectively coordinate palliative care services. Parkland will address this challenge through targeted staff recruitment and training programs as appropriate. Establishing a dedicated inpatient unit, while a challenge, can be addressed as the new hospital is being designed and will open in 2015.

5-Year Expected Outcome for Provider and Patients

The outcome is implementation of a palliative care program that will not only increase the volume of patients cared for through a palliative care model but will reduce the percentage of patients who utilize services such as ICU and ED care in the last days of life

The care plan for a patient under palliative care typically discontinues many high cost tests and invasive treatments and focuses on symptom management and quality of life. As a result,

another outcome will be decreased lengths of stay and costs for patients who receive palliative care services in-house.

Starting Point/Baseline

In FY2012, 911 patients were identified as having palliative care consults. And, of the 210 palliative patients who expired at Parkland, 150 of those patients had an ED visit within 30 days of their death at Parkland.

Rationale

Palliative care programs can improve the quality of life for many patients suffering from chronic and/or terminal conditions[349]. By reducing the amount of invasive testing and treatment and focusing on pain management and quality of life Parkland may also realize cost savings[350]. In a study based on 2004-2007 data in New York, it was determined that patients who received palliative care incurred $6,900 less in hospital costs during a given admission when matched to hospital patients of usual care.[351] Beyond reducing unnecessary service utilization, palliative care has the potential to improve health care quality by encouraging more appropriate and compassionate end-of-life care.[1]

End-of-life care is no longer associated almost exclusively with terminal cancer, but is now used for a variety of other conditions: congestive heart failure, circulatory conditions, COPD, dementia, and congestive heart failure[352]. Some have suggested that palliative and hospice care could be more widely accepted for many dying patients, including children. However, conversely, rigid quality standards and poorly aligned reimbursement incentives frequently discourage appropriate end-of-life care, while incentivizing restorative and technologically intensive treatments. Care coordination near the end of life can improve care for patients with chronic conditions, relieve suffering, and can be used in addition to curative treatment.

Project Components

Required core components of Project Option 2.10 - Use of Palliative Care Programs include:

a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program. *Preliminary discussions have occurred and a team to develop a business case is being identified – a clinical champion has been identified.*

[349] "Integrating Palliative Care into Oncology Practice", Oncology Roundtable, The Advisory Board Company, 2011.
[350] Cost savings associated with US hospital palliative care consultation programs. Morrison RS, Penrod JD, Cassel JB, Caust-Ellenbogen M, Litke A, Sprangens L, Meier DE; Palliative Care Leadership Centers' Outcomes Group. Arch Intern Med. 2008 Sep 8; 168(16):1783-90.
[351] Morrison,R, et al. "Palliative Care Consultation Teams Cut Hospital Costs for Medicaid Beneficiaries." Health Affairs. Mar 2011
[352] MedPAC, 2008

b) Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility. *The implementation plan based on the business plan will include protocols for transitional care for these patients.*
c) Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time. *This will be done in DY5.*
d) Conduct quality improvement for project using methods such as rapid cycle improvement. Parkland will participate in regional collaboratives to share best practices and analyze quality data on a weekly basis. *This will be done through face-to-face meetings/seminars semi-annually as well as improved communications internally with care coordination teams and other providers.*

Milestones and Metrics

- P-1: Develop hospital-specific business case for palliative care and conduct planning activities necessary as precursor to implementing program
    - P-1.1: Business Case
- P-8: Document conditions for which palliative care is consulted
    - P-8.1: Breadth of conditions for which palliative care is consulted
- P-3: Implement palliative care education and training programs for providers that incorporate management of non-cancer patients
    - P-3.1: Palliative care training and education for providers documentation
- P-11: Participate in face-to-face learning at least twice per year with other providers and RHP to promote collaborative learning around shared or similar projects
    - P-11.1: Participate in semi-annual face-to-face meetings or seminars
    - P-11.2: Implement "raise the floor" improvement initiatives established
- P-6: Increase number of palliative care consults
    - P-6.1: Palliative care consults meet targets established by program
- I-10: Among patients who died in hospital, increase proportion of who received a palliative care consult
    - I-10.1: Percent of total in-hospital deaths who had palliative care
- I-12: Implement patient/family experience survey regarding quality of care, pain and symptom management and degree of patient/family centeredness and improve scores
    - I-12.1: Survey developed and implemented and results provided

Unique Community Need Identification Numbers the Project Addresses:

- *CN.13 – Need for Palliative Care Services*

How the Project represents a new initiative

This project is a new initiative for Parkland in that the designed program will be comprehensive and implement an integrated care model through inpatient and outpatient care. A specific inpatient unit would be designated for patients with palliative needs. It has been recently estimated that approximately 20-30 inpatients on any given day are in need of palliative services and are scattered throughout the hospital. This project will provide the opportunity to cohort this group of patients with similar needs – allowing providers and care givers to improve efficiencies and focus on quality of care/life needs for these patients.

The project has no related activities funded by U.S. Department of Health & Human Services.

Related Category 3 Outcome Measures

OD-13: Palliative Care

- IT-13.3 - Reduce % patients with more than one ED visit in the last days of life

Reasons/Rationale for Selecting Outcome Measure

The category 3 outcome above is established by the National Quality Forum (NQF). This non-profit organization's mission is to improve the quality of American healthcare. Those in the American healthcare system are getting older and are in need of more health care services. The ED is not an ideal setting for care for the elderly because of the intense environment. In the ED and ICU the staff members are trained to diagnose problems quickly and save lives. According to the Health and Retirement Study over half (51%) of older patients arrived in the ED in their final month of life. Three quarters of those that went to the ED were admitted to the hospital with 39% of them going to the ICU. A large percentage of the patients (68%) died that were admitted in the hospital. The ED or ICU is not the best environment for palliative care. By implementing this program, visits to the ED and hospital ICU in the last days of life decreases.

Relationship to Other Projects

Proposed projects that relate to establishing a palliative care program include the following:

Unique Project	Option	Project Description
127295703.2.5	2.5.2	Assess cost effectiveness of post-acute care alternatives
127295703.2.7	2.9.1	Enhance patient navigation program
127295703.2.9	2.12.1	Implement care transitions program

Category 4 Related Outcomes

- RD-5: Emergency Department

Relationship to Other Performing Providers' Projects

The only related project (Project Option 2.10) is being submitted by UT Southwestern – University Hospital (175287501.2.2).

We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to this project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. Parkland will also participate in any Outcomes Learning Collaborative that is associated with project outcomes to obtain additional perspectives that may enable improvement of the project. The exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance this project's success.

Project Valuation

Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 6.85 on a 9.0 scale. Factors that influenced this score included:

- Although this project is targeted to address the needs of a smaller patient population, the impact of this project will be profound – enabling patients to obtain compassionate care in a setting tailored to preserve their dignity
- Cost avoidance by providing the right care setting and resources to meet the patients' needs while freeing costly and scarce critical care capacity for patients requiring that higher level of care
- Fulfilling the community need for palliative care services and capacity
- Furthering the operational and financial sustainability of the health system through more cost effective care

Palliative care has been demonstrated to improve quality of life and reduce hospital costs through reduced lengths of stay, medical complications, and overuse of unnecessary, ineffective/marginally effective services; and through transitioning patients to safe hospital discharges with lower likelihood of readmission. Through a comprehensive palliative care program, Parkland will cohort inpatients for more effective and efficient care – driving cost savings – and importantly, preserve scarce intensive care and acute care bed resources to better meet the needs of the patient population.

The value of this program goes beyond the reduction of cost. By expanding palliative care, vulnerable patients who often lack social, financial and supportive resources, will have the accessibility of supportive care at the time it is most needed.

Unique ID: *127295703.2.8*	***Project Option:*** *2.10.1*	***Project Components:*** *2.10.1 (a- d)*	***Title:*** *Establish Palliative Care Program*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.33*	*3.IT-13.3*	*Proportion of patients with more than one ER visit in last days of life*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Develop hospital-specific business case for palliative care and conduct planning activities necessary as precursor to implementing program Metric 1 [P-1.1]: Business Case Goal: Complete business plan Data Source: Business Case write-up; documentation of planning activities Milestone 1 Estimated Incentive Payment (max amount): $3,356,936 **Milestone 2** [P-8] Determine conditions for which palliative care is consulted Metric 2 [P-8.1]: Breadth of conditions for which palliative care is consulted Goal: Analysis of conditions that require palliative care consults Data Source: EHR, palliative care database Milestone 2 Estimated Incentive Payment (max amount): $3,356,936	**Milestone 3** [P-3] Implement palliative care education and training programs for providers that incorporate management of non-cancer patients Metric 3 [P-3.1]: Palliative care training/ education for providers documentation Goal: Establish provider training Documentation: Provide training/ education curriculum Data Source: Database that tracks type and number of training/ education sessions by health care professional category Milestone 3 Estimated Incentive Payment (max amount): $3,433,347 **Milestone 4** [P-11] Participate in face-to-face learning at least twice per year with other providers and RHP Metric 4 [P-11.1] Participate in semi-annual face-to-face meetings Goal: Participation at meetings Data Source: Meeting documentation	**Milestone 5** [P-6] Increase number of palliative care consults Metric 5 [P-6.1] Palliative care consults meet targets established by program Baseline: 911 patients (1,1,74 consults) Goal: Increase 15% Data Source: EHR, claims data Milestone 5 Estimated Incentive Payment (max amount): $3,428,024 **Milestone 6** [I-10] Among patients who died in hospital, increase proportion of those who received a palliative care consults Metric 6 [I-10.1]: Percent of total in-hospital deaths who had palliative care/consult Baseline: 160 patients Goal: Increase 20% Data Source: EHR, claims, registry	**Milestone 7** [I-10] Among patients who died in hospital, increase proportion who received palliative care consult Metric 7 [I-10.1]: Percent total in-hospital deaths who had palliative care/consult Goal: Increase 30% Data Source: EHR, claims, registry Milestone 7 Estimated Incentive Payment (max amount): $1,845,314 **Milestone 8** [P-6] Increase number of palliative care consults Metric 8 [P-6.1] Palliative care consults meet targets established by program Goal: Increase 20% from DY4 Data Source: EHR, claims data Milestone 8 Estimated Incentive Payment (max amount): $1,845,313 **Milestone 9** [I-12] Implement patient/ family experience survey

Unique ID: *127295703.2.8*	***Project Option:*** *2.10.1*	***Project Components:*** *2.10.1 (a- d)*	***Title:*** *Establish Palliative Care Program*	
Parkland Health & Hospital System				*127295703*
Related Category 3 Outcome Measures:	*127295703.3.33*	*3.IT-13.3*	*Proportion of patients with more than one ER visit in last days of life*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 4 Estimated Incentive Payment (max amount): $3,433,347	Milestone 6 Estimated Incentive Payment (max amount): $3,428,024	regarding quality of care, pain and symptom management and degree of patient/family centeredness in care Metric 9 [I-12.1]: Survey developed & implemented and results provided Goal: Survey score improvement over time Data Source: Patient/family experience survey Milestone 9 Estimated Incentive Payment (max amount): $1,845,313
Year 2 Estimated Milestone Bundle Amount: $6,713,872	**Year 3 Estimated Milestone Bundle Amount:** $6,866,694	**Year 4 Estimated Milestone Bundle Amount:** $6,856,048	**Year 5 Estimated Milestone Bundle Amount:** $5,535,940
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):*			**$25,972,554**

Project Option 2.12.1 - Expand Care Transitions Program

Unique Project ID: 127295703.2.9

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare and 7% Commercial Insurance.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY2012 Volumes	Parkland Share of Dallas County Adults	
		% Market Share	Medicaid/ Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Centers	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Intervention: Transitional Care programs focus on patients transferring from one care setting to another. Typically, the medically complex patients are selected for care transition intervention. However, based on predictive modeling research performed in the Parkland Center for Clinical Innovation[353], incorporating complex social factors increased the model's

[353] Med Care. 2010 Nov; 48(11):981-8; An automated model to identify health failure patients at risk for 30-day readmission or death using electronic medical record data; Amarasingham R; Moore, BJ; Tabak, YP, et.al.

accuracy, suggesting that such factors could enhance risk adjustment models designed to compare hospital readmission rates.

This project proposes to design, develop and implement a care transitions program modeled largely around "The Care Transitions Program" design of Eric A. Coleman, MD MPH targeting patients being discharged from an inpatient status with higher social complexity and lower medical complexity. Through a case finding protocol, the existing Discharge Planning function, will identify and refer patients to Transition Coaches who will provide support and guidance in accordance with the program design. This aim of this program will be to offer primary care and prevention, improve health literacy and patient activation, facilitate connections to address social problems thereby reducing readmissions, inappropriate ED use and promoting primary prevention.

Need for the Project: Parkland, as the primary safety net hospital for Dallas County, often functions at capacity in all sites in its continuum of care. Patient demand far outstrips the physical and financial capacity of the system. Accordingly, it is imperative that the system resources are used in the most efficient and effective manner possible – duplication, overuse and waste must be eliminated.

Readmission after hospitalization is costly and consumes both time and valuable resources. Further, both hospitalization and emergency department recidivism deprive the patient of the opportunity to establish or resume stability and effect optimal quality of life. This project will intervene with the most vulnerable patients to identify and overcome barriers to stability, facilitate timely access to appropriate sites of care, and assist the patients and their caregivers to achieve health literacy and self-management which will result in reduced readmissions and emergency department recidivism.

In the national debate regarding the rising cost of health care, prevention is seen as the touchstone of a redesigned health system focused on improving health outcomes. Prevention advocates present the argument that prevention will save money, promote good health and provide a means for controlling health spending growth.

Target Population: The patient population that will be targeted for this intervention will be defined as those fitting in the lowest two quintiles of inpatients (over age 17) based on medical complexity, then further stratified as higher or lower social complexity. The target population pool (approximately 6,000 unique individuals) will come from the higher social complexity half and will, by definition, be primarily Medicaid and indigent patients.

Category 1 & 2 Expected Patient Benefits: Benefits include improved patient outcomes including decreased unnecessary ED visits/readmissions, increased access to needed care, and enhanced self-management skills as well as increased patient and family satisfaction.

Category 3 Outcomes: The FY16 goals include the following improved outcomes:

- IT.3.1: All Cause 30-day Readmission Rate

- Goal: Decrease readmissions rate from 8.74% (2,770/31,683) to 8.5%

Project Description

Parkland will implement a new care transitions program directed to socially complex patients to implement improvements and coordination of care from inpatient to outpatient, post-acute and home care settings in order to prevent unnecessary use of scarce health care resources.

Evidence indicates that social complexity factors play a meaningful role in predicting the risk of readmission – potentially equal to or of greater importance to medical complexity.[354] In recognition of the import of the challenges associated with social complexity, this project proposes to build a new care transitions program to focus on patients identified as having a high degree of social complexity. Research conducted by the Parkland Center for Clinical Innovation has identified social factors that contribute to risk for readmission. The social determinants that will be used to stratify the inpatient population include: gender, age, level of education, payer status, history of mental illness, history of cocaine, number of address changes, marital status, residence in high risk census tract, and admission time between 8 a.m. and 5 p.m. The risk stratification process will consider these factors and those established in other evidence-based research. The target patient population will consist of Parkland discharging adult inpatients with medical complexity consistent with the lower two quintiles for the Parkland inpatient population – a pool of approximately 12,000 unique patients. From that subset, the patient targets will include those in the higher half of social complexity – a target pool of approximately 6,000 unique patients.

Parkland will implement the new care transitions program modeled largely around "The Care Transitions Program" design of Eric A. Coleman, MD MPH. The project and program will be a new extension to the existing Care Coordination and Discharge Planning functions. The major activities of this project will include: care transitions model design and development, model implementation, post-implementation assessment, and ongoing monitoring and improvement.

Model Design

Many of the evidence-based care transitions models have been designed to address elderly patient populations. Although the Coleman model appears to fit well for the Parkland system requirements, a thorough review of the major models will be conducted to assure strong awareness of best practices as the care transitions model is tailored for the Parkland system and this socially complex target population.

Through engagement of a collaborative, cross-continuum team and using the STAAR tools, an analysis of the key drivers for both inpatient readmission and ED recidivism for the target

[354] Med Care. 2010 Nov; 48(11):981-8; An automated model to identify health failure patients at risk for 30-day readmission or death using electronic medical record data; Amarasingham R; Moore, BJ; Tabak, YP, et.al.

populations will be performed. The analysis will identify the factors that will be addressed through the tailored care transitions model.

As currently contemplated, the program activities will center around a team of Transition Coaches, envisioned to be multi-disciplinary team including nurse practitioners and supplemented by other expertise determined appropriate, who will engage with inpatients prior to discharge. The program interventions may include: in-hospital visits, home visits, clinic-based visits, and telephone contact with the patient and the patient family and caregiver(s). Significant goals for the program include substantial improvement in the patient's (or caregiver/guardian) self-management capability and confidence – specifically around medication self-management, health literacy and understanding of personal health history and record, ability to understand and complete necessary medical follow-up, and a recognition of, and understanding of how to respond to, changes in personal health condition.

Model Implementation

Upon completion of the model design and the target population refinement processes, prepare a comprehensive implementation plan. Based on the determinations made through the model design, the appropriate organizational design, leadership and staffing positions will be developed and recruited. The specific implementation steps will be dependent on the final design but will include the following activities: draft and finalize care transitions policies, procedures and protocols; determine and address practice and regulatory requirements related to the services to be provided; establish patient referral interfaces with hospital-based case management; establish data management and reporting capabilities; calibrate the health record to capture care transitions activities with full transparency within the Parkland system; and other activities appropriate to the final model design. A post implementation assessment will be a component of the implementation plan and will be conducted as indicated in the plan.

It is expected that by DY 5, the Care Transitions program for the socially complex patients will have an annual caseload of 1,250 patients. Because the social factors confronting many patients are difficult to address, the caseload has been conservatively estimated to be relatively low for the program.

Throughout the implementation steps, the implementation team will participate in internal and external learning activities including face-to-face learning meetings and "raise the floor" improvement initiatives.

Post Implementation Assessment and Continuous Improvement

A post implementation assessment will be a component of the implementation plan and will be conducted as indicated in the plan. The functional activities of the Care Transitions program will make use of system-wide performance improvement methods and practices.

Goals and Relationship to Regional Goals

The goals are to implement standardized care transitions program and increase the percentage of patients receiving standardized, evidence-based interventions for post discharge care/recovery per approved clinical protocols for care transitions.

Regional 9 goals include improved access to care, improved care coordination and improved provider performance and outcomes. A best-practice care coordination program supports the goals by improving access to appropriate care settings and coordinating care for the patient across the care continuum.

Challenges

The nature of the intervention's target patient population presents the immediate and daunting challenge. It is anticipated that the project team will leverage both internal Parkland knowledge and experience and that of other safety net and social organizations that work with this population. Many of the social problems present difficult if not intractable barriers to success.

As a new initiative, it will be imperative to establish and use clear protocols to identify and enroll targeted patients in the Care Transitions program. It will also be necessary to establish clear interfaces between this program and base Care Management and associated programs so as to best invest and direct the resources of the Care Transitions Program. Again as a new initiative, focused attention must be paid during implementation to measure and modify, as appropriate, the intervention design to assure that the desired outcomes are achieved.

5-Year Expected Outcome for Provider and Patients

Through this intervention, it is anticipated that the enrolled patients will engaged actively in creating a managed post-acute period that will yield benefit not only through the period of intervention enrollment, but will extend to ongoing activation in health self-management. The expected outcome is an increased number of patients who are more appropriately discharged and supported through the post-discharge period based on their complex needs, thus reducing 30-day readmissions.

Starting Point/Baseline

Of 31,683 inpatient discharges for adults (18+ years) in FY2012, All Cause Readmissions Rate was 8.74%~~;~~ The Care Transitions program does not exist today, so the starting point/baseline is 0 patients enrolled.

Rationale

Care transition programs facilitate the movement of patients from one care setting or health care provider to another. In order to improve patient outcomes with simultaneous reductions

in hospital costs, the transition of patients from inpatient to outpatient, and ultimately home is desirable. When patients have serious or complex medical or social problems, the transition of care becomes especially important. Patients may experience problems obtaining and managing their follow-up care treatments, taking and/or acquiring medications, or even understanding care protocols—even more the case among vulnerable and complex patients such as those served at Parkland. The care transition must be safe, effective and efficient to reduce the risk of errors and to achieve maximal benefit in terms of patient recovery.

Parkland Health & Hospital System is at capacity with 37,000+ discharges and 195,000+ patient encounters in the ED per year. Preventing unnecessary readmissions allows Parkland additional capacity and focus to care for patients who are currently in the hospital. Parkland is in the process of establishing a comprehensive case management program whereby significant adjustments to the care process can be made to insure appropriate transitions of care throughout the system including the implementation of a discharge planning program to hopefully reduce readmissions and inappropriate utilization of the ED.

Project Components

The required core components of Project Option 2.12.1 include the following:

a) Review best practices from a range of models (e.g. RED, BOOST, STAAR, INTERACT, Coleman, Naylor, GRACE, BRIDGE, etc.). *Initial work on best practice review brought focus to the Coleman model – further evaluation will be performed as the Parkland model is designed and refined*.

b) Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR) tool) and patient interviews. *Readmissions data from the Dallas Fort Worth Hospital Council and information shared in Utilization Management meetings will be utilized to identify key drivers of readmissions* .

c) Integrate information systems so that continuity of care for patients is enabled. *Parkland has an integrated electronic medical record through EPIC and will review other modules to enhance EPIC specific to patients' complex needs*.

d) Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days. *Analytic work will be performed with focus on patients at risk for readmission and for ED recidivism.*

e) Implement discharge planning program and post discharge support program. *This intervention will be designed to interface effectively with the existing Care Management and Discharge Planning functions.*

f) Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, etc. *This initiative will leverage and extend the work of cross-continuum teams focused on*

care management. Specific teams will be assembled to support model design, model implementation and post-implementation assessment activities.

g) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. *Organizations will have opportunities for face-to-face learnings. Also, groups such as "post-acute teams" may include hospitals and post-acute providers and meet to discuss patient needs. The group can determine collectively how to insure patients get appropriate care and the providers involved determine ways to work towards that (contracting, etc.).*

Milestones and Metrics

- P-1: Develop or implement best practices or evidence-based protocols (such as Partnership for Patients) for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions
    - P-1.1 Metric: Care transitions protocols
- P-2: Implement standardized care transition process
    - P-2.1: Develop care transitions policies and procedures
- P-5: Using a validated risk assessment tool, create a patient identification system
    - P-5.1: Patient stratification system
- P-7: Develop staffing implementation plan to accomplish objectives of program
    - P-7.1: Documentation of staffing plan
- P-12: Participate in face-to-face learning (meetings/seminars) at least twice per year with other providers and RHP to promote collaborative learning around similar projects
    - P-12.1: Participate in semi-annual face-to-face meetings or seminars
    - P-12.2: Implement raise the floor improvement initiatives established at meeting
- I-10: Identify top conditions and other patient characteristics or socioeconomic factors that are common causes of avoidable readmissions
    - I-10.1: Identification and report of those conditions, socioeconomic factors or other patient characteristics resulting in highest rate of readmissions
- I-11: Improve percentage of patients in defined population receiving standardized care according to care transitions policies
    - I-11.1: Number over time of patients receiving standardized, evidence-based interventions per approved clinical protocols

Unique community need identification numbers the project addresses

- *CN.11 - Patient Safety and Quality*
- *CN.12 - Emergency Department Utilization and Readmissions*

How the project significantly enhances an existing delivery system reform initiative

Through the establishment of a comprehensive evidence-based Care Transitions program, care will be appropriately managed for patients from admission to discharge in a systematic, efficient/effective manner.

Related Category 3 Outcome Measure(s)

OD-3: Potentially Preventable Readmissions

- IT-3.1: All Cause 30-day Readmission Rate

The degree to which discharge planning is effective can influence the risk of admissions and readmissions for patients. Patients in the ED and/or hospital need to understand their discharge instructions for recovery and/or for transfer to another facility. Patients may not understand instructions or it may not be well communicated. Better communication can assist in preventing a health care issue from becoming more serious and requiring hospitalization or ED utilization. In particular, the degree to which staff members communicate with patients about their discharge needs and facilitate post discharge care can directly impact the risk of readmission. Readmissions will provide a measure to inform whether the care transitions process is successful for these patients.

Reasons/Rationale for selecting outcome measures

The current readmissions rate for Medicare beneficiaries is almost one in five and those readmission costs are approximately $15 billion annually.[355] Beginning in October 2012, the Centers for Medicare and Medicaid Services (CMS) was given authority to withhold reimbursements from hospitals with excessive readmission rates. Based on the Medicare Payment Advisory Commission's identification of seven top conditions and procedures that accounted for almost 30 percent of potentially preventable readmissions (including heart failure; chronic obstructive pulmonary disease; pneumonia; acute myocardial infarction; coronary artery bypass graft surgery; percutaneous transluminal coronary angioplasty; and other vascular procedures),[356] CMS decided to initially focus efforts on reducing preventable readmissions for congestive heart failure, acute myocardial infarction and pneumonia.

[355] NQF. "NQF Endorses All-Cause Unplanned Readmissions Measures." Release April 24 2012. http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_All-Cause_Unplanned_Readmissions_Measures.aspx

[356] Center for Medicare Advocacy - 2012. http://www.medicareadvocacy.org/2012/05/02/medicare-hospital-readmissions/

While the main intent is to lower readmission rates to improve patient outcomes, the Advisory Board[357] cites other reasons hospitals should focus attention on readmissions including potential financial penalties. Another reason cited and important for Parkland is with reduced readmissions, physicians and care teams can focus on providing quality care to current inpatients. Parkland is at capacity on any given day and when transitions of care are less than optimal there are a variety of baleful consequences: patient recovery suffers, patients are at higher risk of adverse events including medication errors, and patients may experience lapses and/or insufficient care. Readmissions and other adverse events are a disruption for patients and also for the staff who could be treating other patients. The multi-dimensionality of patient transitions from and to a variety of potential health care facilities and settings establishes the need for a truly effective discharge planning process which can reduce readmission rates.

Relationship to Other Projects in RHP Plan

The care transitions program is one component of Care Coordination Redesign and is being implemented in alignment with the patient care navigation program (127295703.2.7). The other related project is s127295703.2.5 – Assess cost effectiveness of post-acute care continuum.

Category 4 Related Outcomes

RD-2: 30-Day Readmissions for All Cause, Diabetes and AMI

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

Related projects (Project Option 2.12) are submitted by performing providers and include:

Performing Provider	Unique Project
Baylor Medical Center at Garland	121790303.2.4
Baylor Medical Center at Irving	121776204.2.4
Baylor University Medical Center	139485012.2.4
Children's Medical Center	138910807.2.4
Tenet – Doctors Hospital at White Rock	094194002.2.2
UT Southwestern Medical Center – Faculty Practice Plan	126686802.2.5
UT Southwestern – University Hospital	175287501.2.3

We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to this project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. Parkland will also participate in any Outcomes Learning Collaborative that is associated with project outcomes to obtain additional perspectives that may enable improvement of the project. The exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance this project's success.

[357] Reducing preventable readmission: Elevating care transitions and enhancing disease management to perfect care across the continuum. Pfenninger D, Bushlow E, Kassen D, and Cardiovascular Round table Advisory Board Company, 2010.

Project Valuation

Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 7.25 on a 9.0 scale. Factors that influenced this score included:

- The strong impact this project will have with respect to intervening with patients among Parkland's vulnerable population at highest social risk for to prevent future complex and/or costly care
- Cost avoidance by providing streamlining and enabling program patients to obtain the right care in the right place at the right time
- Opportunities for partnership and collaboration with the many performing providers in RHP 9 that are pursuing care transitions projects

The value (ratio of benefits to costs) of early intervention and prevention is always difficult to quantify and document. As a primary prevention project, the value produced this intervention program will be accomplished by facilitating stabilization, encouraging patient activation, improving health literacy with the result of preventing or delaying the onset of the acute and chronic diseases that account the most costly health care services.

Health Management Associates (HMA) published a paper in November 2008 that surveyed the literature with respect to evidence of savings associated with chronic disease management.[358] The paper indicates evidence that chronic disease management programs can yield savings ranging from 2.72 to 32.7 dollars saved per dollar invested. The paper also notes that costs tend to be relatively modest, ranging from $100 to $1399 per capita. These factors are extended with respect to the Parkland Care Transitions program enrollment targets in the table below as a demonstration of the range of value that could be derived from this prevention intervention.

Parkland Program Enrollees	Potential Per Capita Program Costs	Ratio of Dollars Saved to Dollars Spent	Potential Value Range
750	$100 - $1399	2.72 to 32.70	$204,000– $ 34,310,475
1,250	$100 - $1399	2.72 to 32.70	$340,000– $ 57,184,125
			$544,000 - $91,494,600

[358] Chronic Disease Management: Evidence of Predictable Savings, Health Management Associates; Jack Meyer, PhD and Barbara Markham Smith, JD November 2008.

The range of potential value is extremely wide, but demonstrates the potential for significant value to be produced by the preventing or delaying the onset of chronic disease.

Unique Identifier: *127295703.2.9*	***Project Option:*** *2.12.1*	***Project Components:*** *2.12.1 (a- g)*	***Title:*** *Expand Care Transitions Program*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.34*	*3.IT-3.1*	*-All Cause 30-day Readmission Rate* *-*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: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 Goal: Care transitions Data Source: Documentation Milestone 1 Estimated Incentive Payment (max amount): $3,171,726 **Milestone 2** [P-2]: Implement standardized care transition process Metric 2 [P-2.1]: Care transitions policies and procedures Goal: Care transitions policies and procedures Data Source: Documentation Milestone 1 Estimated Incentive Payment (max amount): $3,171,726	**Milestone 3** [P-5] Using a validated risk assessment tool, create a patient identification (stratification) system Metric 3 [P-5.1]:Patient stratification system Goal: Establish stratification system Data Source: Submission of risk assessment tool and patient stratification report and description of provider utilization of report findings Milestone 3 Estimated Incentive Payment (max amount): $2,162,614 **Milestone 4** [P-7] Develop staffing implementation plan to accomplish goals/objectives of care transitions program Metric 4 [P-7.1]: Documentation of staffing plan Goal: Establish/implement staffing plan Data Source: Staffing and implementation plan Milestone 4 Estimated Incentive Payment (max amount): $2,162,614	**Milestone 6** [I-10] Identify top conditions and other patient characteristics or socioeconomic factors that are common causes of avoidable readmissions Metric 7 [I-10.1]: Identification and report of those conditions, socioeconomic factors or other patient characteristics resulting in highest rate of readmissions Baseline: No report Goal: Establish report and ongoing reporting process to continually update and analyze factors Data Source: EMR report/analysis Milestone 6 Estimated Incentive Payment (max amount): $3,238,892 **Milestone 7** [I-11] Improve percentage of patients in defined population receiving standardized care according to care transitions policies	**Milestone 8** [I-11] Improve percentage of patients in defined population receiving standardized care according to care transitions policies Metric 9 [I-11.1]: Number over time of patients receiving standardized, evidence-based interventions per approved clinical protocols Baseline: None (no protocols exist) Goal: Increase to an annual caseload of 1,250 the patients receiving standardized, evidence-based interventions per approved clinical protocols (500 greater caseload than DY 4) Data Source: Hospital data systems Milestone 8 Estimated Incentive Payment (max amount): $5,230,509

Unique Identifier: *127295703.2.9*	***Project Option:*** *2.12.1*	***Project Components:*** *2.12.1 (a- g)*	***Title:*** *Expand Care Transitions Program*	
Parkland Health & Hospital System				*127295703*
Related Category 3 Outcome Measures:	*127295703.3.34*	*3.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 5 [P-12]: Participate in face-to-face learning (meetings/seminars) at least twice per year with other providers and RHP to promote collaborative learning around shared/ similar projects Metric 5 [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by RHP Goal: Establish semi-annual face-to-face meetings / seminars Data Source: Meeting documentation Metric 6 [P-12.2]: Implement "raise the floor" improvement initiatives established at semiannual meeting Goal: Establish semiannual meetings and conduct "raise the floor" improvement initiatives Data Source: Documentation of initiatives agreed upon and implementation documentation Milestone 5 Estimated Incentive Payment (max amount): $2,162,614	Metric 8 [I-11.1]: Number over time of patients receiving standardized, evidence-based interventions per approved clinical protocols Baseline: None (no protocols exist) Goal: Increase to an annual caseload of 750 the patients receiving standardized, evidence-based interventions per approved clinical protocols Data Source: Hospital data systems Milestone 7 Estimated Incentive Payment (max amount): $3,238,892	
Year 2 Estimated Milestone Bundle Amount: $6,343,452	**Year 3 Estimated Milestone Bundle Amount:** $6,487,842	**Year 4 Estimated Milestone Bundle Amount:** $6,477,784	**Year 5 Estimated Milestone Bundle Amount:** $5,230,509
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):			**$24,539,587**

Project Option 2.4.3 – Patient Satisfaction: Improve Patient Experience for Inpatient Care

Unique Project ID: 127295703.2.10

Performing Provider Name/TPI: Parkland Health & Hospital System /127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare and 7% Commercial Insurance.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY2012 Volumes	Parkland Share of Dallas County Adults	
		% Market Share	Medicaid/ Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Centers	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Intervention. This project seeks to improve the inpatient satisfaction scores for Parkland by creating a position on the senior leadership team responsible for developing an effective service excellence program.

Need for Project. The most recent Hospital Compare patient satisfaction survey overall score for Parkland's inpatient was reported at 65% which is below the Texas and national average.

Target Population. The target population includes all patients who have an inpatient stay at Parkland and are eligible for an HCAHPS survey (according to CMS inclusion/exclusion criteria). While the largest group of Parkland's inpatient payer mix is unfunded/Medicaid (76%), this initiative is not payer specific and will be directed to include all patients.

Category 1 or 2 Expected Patient Benefits: This project seeks to improve the patient experience at Parkland as will be determined through the Press Ganey and HCAHPS patient satisfaction survey tools.

Category 3 Outcomes: The FY2016 outcome will be improved patient satisfaction.

- IT-6.1-Percent improvement over baseline for patient satisfaction scores. Goal is to improve patient satisfaction scores for those patients rating 9 or 10 out of 10 on HCAHPS overall rating score by 6 percentage points from baseline.

Project Description

This project proposes to target improvement in Parkland's inpatient satisfaction score, as measured by the HCAHPS instrument and supplemented by Press Ganey's validated metrics, innovative, data-driven solutions and strategic consulting. To meet this goal and support institution-wide enhancement of customer service delivery, customer service must be restructured and centralized as a system-wide function under the leadership of a Service Excellence Manager. We anticipate this project to serve and to improve the experience of care for approximately 145,556 inpatients over the demonstration period (DY2-DY5) based on the adult FY2012 yearly volume in the table above. We do currently randomly survey a large proportion of inpatients, yielding a total of 5,926 returned surveys for FY2012.

A Service Excellence Manager (1 FTE) position and appropriate support staff will be recruited. The Service Excellence Manager's purview will include responsibilities for facilitating and coordinating hospital-wide performance improvement initiatives and unit-level service excellence consulting. This role is a well-established industry "Best Practice" model for customer service enhancement and ultimately the improvement of patient satisfaction scores.

The Service Excellence Manager shall report directly to a senior member of the hospital executive team such as the Chief Operating Officer or other senior level operational vice president role. The Service Excellence Manager will have institutional authority to implement performance improvement initiatives, standards of behavior, staff training, and reinforcement programs house-wide as necessary to fulfill the goal of improving customer satisfaction.

Patient satisfaction survey administration will remain supported by the Health Systems Research Department, and the function of coordinating all aspects of survey administration and report distribution will remain with the current survey administrator and support staff, as well as providing the primary liaison role with the survey vendor.

In addition to the new position for Service Excellence, specific objectives of this project include:

a) Establish and chair a steering committee to monitor/coordinate improvement activities

b) Promulgate and enforce codes of conduct regarding staff interactions with patients

c) Work with HR Department to develop new employee screening for service excellence aptitude and establish minimum thresholds for employment

d) Identify and implement performance improvement initiatives

e) Implement and monitor a house-wide process to reward and recognize high performers

f) Participate in learning collaboratives with providers, vendors, and other professional associations

Goals and Relationship to Regional Goals

The goal of this project is to target improvement of Parkland's inpatient satisfaction score, as measured by the HCAHPS instrument and supplemented by Press Ganey's validated metrics.

RHP 9 regional goals include improved access to care, improved care coordination and management and improved provider performance (quality, clinical and financial outcomes). Although not specific to quality, clinical or financial outcomes, this initiative is to improve provider performance specific to patient satisfaction as one of Parkland's strategic objectives.

Challenges

Motivating inpatient clinical staff to focus and expend energy on patient satisfaction improvement and customer service excellence is a major challenge. Performance improvement strategies targeting satisfaction are not traditionally embraced by physicians, nurses, and clinical staff, although that culture is necessarily changing. Understandably, providing top quality medical care, while avoiding medical errors is at the forefront of bedside staff's mind. Parkland's patient population is highly complex and requires precision and focus on the medical care provided. Redirecting their focus requires extra effort as their time is constrained with the volumes of patients Parkland sees. However, establishing a centralized role to identify high and poor performance, establish targets and promulgate results and to help implement and support improvement activities will provide clinical staff the resources and motivation necessary to achieve those improvements.

5-Year Expected Outcome for Provider and Patients

The outcome of this project is to increase inpatient HCAHPS scores from the current levels. This DSRIP 5-year goal is to improve the percentage of patients rating 9 or 10 out of 10 on the HCAHPS "Overall Rating" question scores to minimally exceed current CMS established Value-Based Purchasing Achievement thresholds (VBP; CMS Final Rule April 2011) by year 5. Further, to achieve statistically significant improvements in the Press Ganey proprietary standard question overall mean score, and achieve the 25th percentile of the Press Ganey University Healthcare Consortium client benchmark by year 5 for inpatients.

Starting Point/Baseline

Baseline measurements already exist and will continue to be measured for both HCAHPS and Press Ganey's standard overall mean score. The HCAHPS baseline is 64% of patients who score '9 or 10' out of 10 on the "Overall Rating" question on the patient survey[359].

The Press Ganey baseline to be used is 83.6, which is the mean of the standard questions.[360]

Rationale

Parkland has identified patient satisfaction is a strategic goal for the organization. However, there has been little to no improvements in inpatient satisfaction scores since the contract arrangement with Parkland's new vendor, Press Ganey - CMS certified HCAHPS vendor, began April 1, 2011. Regarding the CMS-mandated HCAHPS measures, Parkland's publically reported "Overall Rating" score has declined 4 percentage points from the July 2010-June2011 reporting period to the most recent publically reported period of April 2011-March 2012 (from 68% Top Box to 64% Top Box respectively). The Press Ganey proprietary inpatient measures have vacillated up and down minimally and have remained within a point or two of the same mean score since the survey's implementation. Parkland's overall satisfaction rating using the Press Ganey metrics has been in the bottom fifth of percentile ranks in three different benchmark groups since the first quarter of measurement.

Excellence in patient care requires an understanding of the patient's perception of the quality and services they received. Patient centered satisfaction surveys measure quality of care and service from the patients view point and are thus, indicators of the hospital's performance. Their goal is to help hospitals monitor quality of service and elucidate opportunities for improvement; thereby, facilitating the development of strategies to enhance quality and those services. Most importantly an institution's success is the creation of experiences that meet and exceed patient expectations. Toward that end, patients' evaluations of services are necessary for performance improvement so that successes can be celebrated and service deficiencies identified and corrected. Equally important is insuring patient satisfaction reports are brought to executive leadership through a regularly scheduled executive report/dashboard. This is being implemented and patient satisfaction will be an element of that dashboard.

A best practice is to have a consolidated organization-wide effort towards patient satisfaction. This effort requires strong support from executive leadership, thus establishing a role at that level within the organization sets direction. Current service excellence initiatives are fragmented, inconsistent, and generally lack the momentum necessary to produce institution-wide improvements in satisfaction scores and percentile rankings. Resource recovery, patient complaints and grievances are addressed by the Patient Relations Department, while the patient satisfaction survey is administrated by the Health Systems Research Department and

[359] CMS Hospital Compare Preview Report: Improving Care Trough Information—Inpatient Hospital Performance. Reporting period is April 2011 through Mar 2012 Discharges

[360] Press Ganey on-line reporting tool – FY2012

hospital services, units and departments are individually and autonomously responsible for initiating and implementing patient satisfaction performance improvement processes.

Project Components

There are no required core components for Project Option 2.4.3 - Other option to implement an innovative and evidence-based intervention that will lead to improve patient satisfaction for providers that have an identified need or unsatisfactory performance in this area.

Milestones and Metrics

- P-1: Appoint Service Excellence Manager executive accountable for experience performance
    - P-1.1: Documentation of executive assigned responsibility
- P-3: Establish steering committee comprised of exec. leaders, staff and patient families to implement improvements in patient experience (Chaired by Service Excellence Manager)
    - P-3.1: Documentation of committee proceedings and list of committee members
- P-X: Implement and monitor a house-wide process to reward and recognize customer service high performers, motivate low performers
    - P-X.1:
        a) Widely promulgate/re-enforce codes of conduct re: staff-patient interactions
        b) Establish service standards & targets
        c) Establish performance indicators, incentives, and reinforcements
        d) Participate in learnings with providers, vendors, professional associations
- P-X: Establish and train "Service Coaches" from among front line inpatient clinical management staff to train their bedside staff about service standards of behavior, customer service excellence initiatives, and behaviors
    - P-X.1: Conduct Service Excellence training sessions among inpatient clinical managers. Promulgate and reinforce codes of conduct re: staff-patient interactions
- P-X: Establish new employee screening procedures for service excellence aptitude.
    - P-X.1: Work with HR Department to develop/implement new employee screening for service excellence aptitude. Establish minimum thresholds for employment.
- P-17: Review project data and respond with tests of new ideas, practices, tools, solutions
    - P-17.1: Number of new ideas, practices, solutions tested
- Data Source: Description of new ideas, practices; summarized quarterly
- I-18: Develop regular organizational display(s) of patient experience data dashboards.
    - I-18.1: Number of organization-wide displays re: patient experience performance
- I-Y: Develop regular organizational display(s) of reward and recognition program
    - I-Y.1: Number of organization-wide displays - reward/recognition

- I-16: Improve inpatient satisfaction/experience scores on HCAHPS composite domains & selected Press Ganey proprietary "priority driver" questions
    - I-16.1: Percent improvement over baseline of patient satisfaction scores for a specific tool. (HCAHPS composite domain question scores)
    - I-16.2: Percent improvement over baseline of patient satisfaction scores for a subset of targeted improvement measures (Press Ganey individual question scores)
    - I-16.3: Demonstrate increase in performance relative to other providers in same RHP and other RHPs, and in contrast with state benchmark

Unique Community Needs Identification

There are no specific community needs identified for patient satisfaction

How the Project significantly enhances an existing delivery system reform initiative

Patient satisfaction is a strategic initiative for Parkland and while this initiative has specific and new recommendations, the initiative itself – to increase patient satisfaction – is not new. All of the recommended projects have an innate objective to increase patient satisfaction for our patients. Strategically, all projects are to improve the key elements of the care continuum to provide our patients more access to care when they need it and also services to address their non-medical care needs (such as interpretation services), which will improve patient outcomes and patient satisfaction.

The project has no related activities funded by U.S. Department of Health & Human Services.

Related Category 3 Outcome Measure(s)

OD-6: Patient Satisfaction

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

Patient-centered care includes patients' perceptions about the quality and their satisfaction with that care. Satisfaction surveys measure quality of care and service from the patients view point and are thus, indicators of the hospital's performance. Most importantly an institution's success is the creation of experiences that meet and exceed expectations. Monitoring improvements in that success by using publically reported data will create incentives for staff to improve their patients' experience of care.

Relationship to Other Projects

There are no related Parkland projects although patient satisfaction is an organizational goal for all departments and as such is an objective for every project.

Category 4 Related Outcomes

- RD-4: Patient-centered HealthCare: Patient Satisfaction

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborates

RHP 9 projects focusing on patient satisfaction have been submitted and include:

Performing Provider	Unique Project
Denton Regional Medical Center (HCA)	111905902.2.2
Las Colinas Medical Center (HCA)	020979301.2.2
Medical Center of Lewisville (HCA)	094192402.2.1

We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to this project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. Parkland will also participate in any Outcomes Learning Collaborative that is associated with project outcomes to obtain additional perspectives that may enable improvement of the project. The exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance this project's success.

Project Valuation

Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 5.30 on a 9.0 scale, mostly due to the specific focus of this project to improve the patient experience at Parkland.

Patient satisfaction has been previously linked in the literature to a number of outcomes for patients and organizations both medical and financial. Better patient satisfaction has been associated with reduced risk of medical malpractice lawsuits. In one study patients in the bottom third of the Press Ganey benchmarks were 110 times more likely to experience malpractice law suits than those in the top third (Stelfox, Gandhi, Orav & Gustafson, 2005)—Parkland inpatient satisfaction scores have been consistently in the bottom third of Press Ganey's benchmarks. Law suits have also been shown to be significantly related to number of patient complaints (Press Ganey 2007). Service recovery and improved satisfaction scores can be expected to mitigate liability exposure, while better patient satisfaction has been shown to increase revenue. One study of physician practices determined that a 5% dissatisfaction rate equated to a $150,000 loss per physician in revenue (Drain & Kaldenberg, 1999). In 2006, malpractice payments averaged $308,593 (Kaiser Family Foundation 2007) per claim, largely due to poor communication between patients and physicians not negligence (23% of claims result from negligence; Phillips et.al. 2004)

Improved patient satisfaction has been repeatedly associated with financial ROI (return on investment). All studies indicate increases in net operating margins with improved patient satisfaction, especially among those at the top deciles (Press Ganey 2010). Further, numerous studies report that satisfied patients cost less to care for because they use fewer resources and experience fewer stress complications. For example Duke Children's hospital increased patient and employee satisfaction yielded an average $4,389 reduction in cost per case (Meliones 2000), while Baptist Health System achieved and average reduction of $1,154 (Jackson, Sistrunk, & Staman, 2003). Moreover Baptist Health System, with an increased focus on patient satisfaction, experienced a length of stay drop of 1.3 days (Jackson, Sistrunk, & Staman, 2003). Overall, patients who are satisfied with their care do not complain as much, do not want to sue, have fewer complications, and are associated with improved staff and physician engagement.

Given the financial impacts of improving patient satisfaction based on the above studies, this project may potentially return a cost savings to the organization of between $167,971,624 and $638,845,284 over four years (36389 inpatients per year*$1,154 or $4,389*4 years) or per DY average ranging from $41,992,906 to $159,711,321.

Using the reduced LOS figure of 1.3 and Parkland's FY11 patient data (FY11 Adult inpatient volume 36,276), a potential DY savings of $62,197,155.00 could be obtained by the cost savings associated with the reduced LOS (FY11 LOS=5.1/Direct Cost per patient $6,724; Revised LOS=3.8/Direct Cost per patient $5,009; cost per patient savings $1,715; 36,389*$1,715=$62,197,155.00 per DY savings)

Either methodology regarding reduced cost per case or reduced costs per patient LOS produces an amount which is potentially well in excess of the $24,776,800 valuation, even without the potential savings that could be realized by reductions in malpractice lawsuit awards.

Unique Project: *127295703.2.10*	***Project Option:*** *2.4.3*	***Project Components:*** *2.4.3*	***Title:*** *Increased Inpatient Satisfaction*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.37*	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Appoint executive accountable for experience performance or create percentage of time in existing executive position for experience performance. (Establish Service Excellence Manager role with support staff) Metric 1 [P-1.1]: Documentation of executive assigned responsibility Data Source: Organizational chart Milestone 1 Estimated Incentive Payment (max amount): $1,697,760 **Milestone 2 [P-3]**: Establish steering committee comprised of organizational leaders, staff, and patient families to implement and coordinate improvements in patient experience. (Chair to be Service Excellence Manager, attended by operational executive responsible for satisfaction improvement) Metric 2 [P-3.1]: Documentation of committee proceedings and list of committee members Data Source: Meeting minutes,	**Milestone 4 [P-X]** Implement and monitor a house-wide process to reward and recognize customer service high performers, motivate low performers Metric 4 [P-X.1]: a. Widely promulgate/re-enforce codes of conduct regarding staff interactions with patients b. Establish service standards & targets c. Establish performance indicators, incentives, and reinforcements d. Participate in learning engagements with other similar providers, vendors, professional associations Data Source: Program documentation Milestone 4 Estimated Incentive Payment (max amount): $1,302,304	**Milestone 8 [I-18]**: Develop regular organizational display(s) of patient experience data dashboards. Metric 8 [I-18.1]: Number of organization-wide displays regarding patient experience performance Baseline: Quarterly data refresh/ postings Goal: Increase number of displays and communication to staff. Data Source: Display and internal communication Milestone 8 Estimated Incentive Payment (max amount): $1,733,713 **Milestone 9 [I-Y]:** Develop regular organizational display(s) of reward and recognition program Metric 9 [I-Y.1]: Number of organization-wide displays - reward/recognition Baseline: 0 Goal: Increase number of displays and communication to staff Data Source: Display and internal communication	**Milestone 11 [I-16]**: Improve inpatient satisfaction/experience scores on HCAHPS composite domains: • Communication with Nurses, • Response of Hospital Staff, • Communication with Doctors, • Patient's room & bathroom clean, • Room quiet, • Pain Management, • Communication about Medicines, • Discharge Information. Metric 13 [I-16.1]: Percent improvement over baseline of patient satisfaction scores for a specific tool. (HCAHPS composite domain question scores) Numerator: Number patients responding "always" to each domain composite question. Denominator: Total number patients answering each question in composite domains. Baseline (April 2011-Mar 2012 CMS publically reported period). Data:

Unique Project: *127295703.2.10*	***Project Option:*** *2.4.3*	***Project Components:*** *2.4.3*	***Title:*** *Increased Inpatient Satisfaction*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures:	*127295703.3.37*	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
agendas, participant list, and/or list of committee members Milestone 2 Estimated Incentive Payment (max amount): $1,697,761 **Milestone 3 [P-11]** Orchestrate improvement work on identified experience targets (targets to be decided by Service Excellence Manager and steering Committee; however, the targets must be drawn from HCAHPs survey domains and Press Ganey proprietary questions or domains) Metric 3 [P-11.1]: Submission of implementation plan (Identify targeted questions & "priority drivers," establish score improvement evaluation and reporting processes) Data Source: Implementation plans Milestone 3 Estimated Incentive Payment (max amount): $1,697,761	**Milestone 5 [P-X]:** Establish and train "Service Coaches" from among front line inpatient clinical management staff to train their bedside staff about service standards of behavior, customer service excellence initiatives, and behaviors Metric 5 [P-X.1]: Conduct Service Excellence training sessions among inpatient clinical managers. Widely promulgate and enforce/reinforce codes of conduct re: staff interactions with patients Data Source: Program documentation Milestone 5 Estimated Incentive Payment (max amount): $1,302,304 **Milestone 6 [P-X]:** Establish new employee screening procedures for service excellence aptitude. Metric 6 [P-X.1]: Work with HR Department to develop and implement new employee screening for service excellence	Milestone 9 Estimated Incentive Payment (max amount): $1,733,713 **Milestone 10 [I-16]**: Improve inpatient satisfaction/experience scores on HCAHPS composite domains: • Communication with Nurses, • Response of Hospital Staff, • Communication with Doctors, • Patient's room & bathroom clean, • Room quiet, • Pain Management, • Communication about Medicines, • Discharge Information. Metric 10 [I-16.1]: Percent improvement over baseline of patient satisfaction scores for a specific tool.	• Comm/ with Nurses, 68% • Resp/ of Hospital Staff, 54% • Comm/ with Doctors, 76% • Room/bath clean, 61% • Room quiet, 47% • Pain Management, 65% • Comm/ Medicines, 58% • Discharge Inform 83% Goal: 6 percentage point improvement in % of patients rating "Always" to each composite domain specified over baseline. Data Source: HCAHPS Patient satisfaction survey http://www.hospitalcompare.hhs.gov/ Metric 14 [I-16.2]: Percent improvement over baseline of patient satisfaction scores for a subset of measures that provider targets for improvement in

Unique Project: *127295703.2.10*	***Project Option:*** *2.4.3*	***Project Components:*** *2.4.3*	***Title:*** *Increased Inpatient Satisfaction*	
Parkland Health & Hospital System				*127295703*
Related Category 3 Outcome Measures:	*127295703.3.37*	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	aptitude. Establish minimum thresholds for employment. Milestone 6 Estimated Incentive Payment (max amount): $1,302,304 **<u>Milestone 7</u> [P-17]** Review project data and respond with tests of new ideas, practices, tools, solutions. <u>Metric 7</u> [P-17.1]: Number of new ideas, practices, solutions tested Data Source: Description of new ideas, practices; summarized quarterly Milestone 7 Estimated Incentive Payment (max amount): $1,302,304	(HCAHPS composite domain question scores) Numerator: Number patients responding "always" to each domain composite question. Denominator: Number of patients answering each question in composite domains Baseline (April 2011-Mar 2012 CMS publically reported period). Data: • Comm/ with Nurses, 68% • Resp/ of Hospital Staff, 54% • Comm/ with Doctors, 76% • Room/bath clean, 61% • Room quiet, 47% • Pain Management, 65% • Comm/ Medicines, 58% • Discharge Inform 83% Goal: 3 percentage point improvement in % of patients rating "Always" to each composite domain specified over baseline. Data Source: HCAHPS Patient satisfaction survey Source: http://www.hospitalcompare.hhs.gov/	specific tool. (Improve Press Ganey proprietary inpatient Standard Overall mean satisfaction/experience score—composite mean score of 32 non-HCAHPS proprietary patient experience questions across all aspects of inpatient admission experience) Baseline: 83.6 Fiscal year 2012 average. Goal: Statistically significant increase in Press Ganey Standard overall mean score from baseline. Data Source: Press Ganey ~~on-line reporting tool~~. Press Ganey inpatient satisfaction survey results. <u>Metric 15</u> [I-16.3]: Demonstrate increase in inpatient performance relative to other providers in same RHP, comparative with similar organization providers in other RHPs, and in contrast with state benchmark Baseline: 19th percentile University Healthcare Consortium Press Ganey Client Benchmark (based on Fiscal year 2012 average score). Goal: ~~Statistically significant~~ Increased performance to 25th percentile of

Unique Project: *127295703.2.10*	***Project Option:*** *2.4.3*	***Project Components:*** *2.4.3*	***Title:*** *Increased Inpatient Satisfaction*	
Parkland Health & Hospital System				*127295703*
Related Category 3 Outcome Measures:	*127295703.3.37*	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Milestone 10 Estimated Incentive Payment (max amount): $1,733,714	University Healthcare Consortium Press Ganey Client Benchmark. Data Source: Press Ganey inpatient satisfaction survey results. Milestone 11 Estimated Incentive Payment (max amount): $4,199,679
Year 2 Estimated Milestone Bundle Amount: $5,093,282	**Year 3 Estimated Milestone Bundle Amount:** $5,209,216	**Year 4 Estimated Milestone Bundle Amount:** $5,201,140	**Year 5 Estimated Milestone Bundle Amount:** $4,199,679
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):*			**$19,703,317**

Project Option 2.1.1 – Enhance/Expand Medical Homes – Family Medicine

Unique Project ID: 127295703.2.11

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare and 7% Commercial Insurance.

Parkland operates a 725-adult bed and 65-neonatal bed acute care hospital, a Level I Trauma Center with the only ACS certified burn center in the region, 95 Specialty Clinics, 12 community health centers and 11 school-based clinics located throughout Dallas County. On an annual basis, the Parkland system provides care to approximately 290,000 individuals through approximately 1,400,000 encounters. Fiscal Year 2012 Statistics include:

Services	FY2012 Volumes	Parkland Share of Dallas County Adults	
		% Market Share	Medicaid/ Self-Pay/ Charity
Discharges	37,515		
- Adult	36,389	17%	42%
- Neonatal	1,126	27%	39%
Emergency Services	195,947	23%	36%
Deliveries	11,348	30%	46%
Ambulatory Visits	1,031,311	n/a	n/a
- Community Centers	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Intervention. This project will increase the number of patients enrolled in medical homes within the campus-based primary care clinics – Family Medicine and Primary Care Internal Medicine (PCIM). The clinics, unlike the COPC primary care network, are campus-based teaching clinics that provides approximately 40,000 clinic visits annually.

Need for Project. Parkland provides almost 1 million clinic visits (62% unfunded/19% Medicaid) and 200,000 ED visits (64% unfunded/22% Medicaid) annually. The medical home model provides the opportunity to better coordinate care for those patients who may be accessing the system in an ineffective, sporadic manner. For Parkland, capacity is reached in the ED and the clinics and without improving the coordination of care for patients who need care management, there can be no relief to the care delivery infrastructure. Currently, Parkland provides less than ¼ of the care needed for the population <200% FPL in Dallas County. The

demand for primary care will always outrun supply in Dallas County but better coordination of care may provide some relief and also will improve care for those enrolled in the medical home. The Family Medicine and the PCIM clinic each provide approximately 20,000 annual visits, of which the majority of visits are for diabetes and hypertension so the medical home model will be utilized to improve care management of identified populations that utilize campus-based primary care services.

Target Population. In FY2012, the Family Medicine Clinic provided 19,259 visits and the PCIM clinic provided 19,209 visits. More than 80% of the patients seen in Parkland's ambulatory clinics are unfunded/Medicaid. The target population includes patients seen in the Family Medicine and PCIM clinics and the focus will be on enrolling patients into the medical home. The anticipated number of patients to be enrolled through the campus-based primary care clinics is approximately 5,000 (15% of the total).

Category 1 or 2 Expected Patient Benefits. This project seeks to increase the number of primary care campus-based clinic patients who are managed through the medical home model.

Category 3 Outcomes/Goal. The Family Medicine clinic has established the following FY16 goals:

- IT-1.1: Third next available appointment
  - Goal: Reduce the wait from 28 to 20 days (Family Medicine)
- IT-1.12: Diabetes – retinal eye exams
  - Goal: Increase % of patients with diabetes who receive retinal eye exams from 48% in FY12 (235/483) to 80%.
- IT-1.13: Diabetes – foot exams
  - Goal: Increase % of patients with diabetes receiving foot exams from 21% in FY12 (105/483) to 80%

Project Description

Parkland's campus-based primary care clinics - Family Medicine and Primary Care Internal Medicine (PCIM) clinics will achieve NCQA designation as a Medical Home and enroll eligible patients into a medical home model. In a collaborative effort, UT Southwestern will implement workforce training regarding medical home concepts to improve patient outcomes and better meet future health care challenges for residents in Dallas County.

Parkland is the largest provider of primary care for uninsured and low-income patients in Dallas County. While the Parkland COPC network of primary care clinics provides the lion share of primary care services to Parkland patients, the Family Medicine clinic and PCIM clinic provides approximately 40,000 annual visits. The clinics are campus-based teaching clinics with UTSW faculty attending physicians. In an effort to insure focus is consistent, Parkland will seek NCQA designation as a Patient-Centered Medical Home and UTSW will provide necessary training and education to insure providers are well-versed in the PCMH model, its vision and rationale.

Goals and Relationship to Regional Goals

Regional goals include improved access to care, improved care coordination and management and improved provider performance (quality, clinical and financial outcomes). The medical home model provides the foundation to all of these goals. Patients who have designated medical homes have better access to the care they need through a medical home team who coordinates and manages their care throughout the continuum. The medical home model also establishes the infrastructural elements for improved performance through an established panel of patients and standardized protocols/ polices/ procedures related to diseases and chronic conditions. By seeking NCQA designation, the clinic providers are committed to implementing the patient-centered medical home model in that clinic.

UT Southwestern intends to establish more training and educational opportunities in the campus-based clinics by enhancing the current curriculum to insure the future workforce is prepared to care for patients in a medical home model.

Challenges

The biggest challenge for Parkland is demand for primary care services is 4 times the supply in Dallas County for the low income population (<200% FPL). Per the Community Health Needs Assessment more than 43% of the Dallas County population (2.4 million) has an income below 200% of FPL and Parkland currently provides less than ¼ of the need for primary care. The Family Medicine Clinic is one clinic serving this population in providing 20,000 annual visits in a traditional teaching model. To incorporate the medical home model, a broader medical home team must be put into place and every inch of current clinic space utilized and with current capacity constraints, some innovative ideas are required to add staffing and space without reducing patient volume.

5-Year Expected Outcome for Provider and Patients

The outcome will be more patients enrolled in a medical home model and receiving coordinated and well-managed care. Additionally, with a focus on training the workforce, there is opportunity to insure clinicians will have adequate education/training regarding the medical home concept and as residents move on, they will take that education and training with them thus creating a ripple effect as more providers utilize the medical home concept in their practice across the region, state, nation.

Starting Point/Baseline

In fiscal year 2012 the Family Medicine clinic provided 18,116 completed appointments (19,259 total visits). Specifically, Family Medicine clinic providers treated 483 patients with diabetes in FY12. The current third next available appointment for the campus-based clinic is 28 days out.

Rationale

The Patient-Centered Medical Home (PCMH) model promotes long-term partnerships between physicians and patients as well as a coordinated team approach to primary health care. The care team comprised of a physician, nurse and case manager is assigned to each family and takes a proactive approach to care by addressing all the patient's needs at one appointment. Depending on the patient's needs, support may come from other staff members such as dietitians, financial counselors, mental health providers and language support specialists. The 2011 standards for Patient-Centered Medical Home are as follows[361]:

1. Enhance Access/Continuity
2. Identify/Manage Patient Populations
3. Plan/Manage Care
4. Provide Self-Care Support/Community Resources
5. Track/Coordinate Care
6. Measure/Improve Performance

The Patient-Centered Primary Care Collaborative released a report that concluded there has been an improvement quality of care and patient experience while reducing cost of care on some measures including ED utilization.[362] Other research has shown similar findings as well as reduced use of hospitalization and overall savings.[363] Yet another study evaluated a PCMH project in a group practice and found not only significant improvement in the quality of clinical care and patient experience but also in provider experiences (reduced burnout).[364]

In addition to improved quality outcomes, the medical home model provides a coordinated care approach and as more providers utilize the model to care for patient with specific needs, the care continuum can be more appropriately balanced. Patients within the medical home will be less likely to seek care in inappropriate settings such as the ED. With a more focused set of patients designated for providers, patients who need intermittent care can be directed to other providers based on their availability. The shift to identifying panels must occur to streamline the care by type of patient (in need of medical home, in need of intermittent care, etc.) and develop the care continuum based on patient acuity and need to be seen.

[361] National Committee for Quality Assurance. "Patient-Centered Medical Home Standards". NCQA. 2011.
[362] The Patient-Centered Primary Care Collaborative, The Commonwealth Fund and the Alliance for Health Reform. "Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States." 2009. Updated 2010.
[363] Fields, D, Leshen, E, Patel, K. "Analysis & commentary. Driving quality gains and cost savings through adoption of medical homes." Health Affairs. May 2010; 29(5); 819-26.
[364] Reid, RJ, et al. 'Patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation." American Journal Managed Care. September 1, 2009; 15(9); e71-87.

Project Components

Parkland proposes to meet all required project components for this project including:

a) Utilize gap analysis to asses/ measure hospital-affiliated PCPs' NCQA PCMH readiness. *Family Medicine and PCIM physicians meet with COPC physicians and staff and are developing an operational readiness assessment for medical home achievement.*
b) Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status. *The Family Medicine and PCIM clinic leadership will perform a feasibility study in parallel with the operational readiness assessment.*
c) Conduct educational sessions for primary care physician practice offices, hospital boards, medical staff and senior leadership on PCMH (elements, rationale and vision). *Parkland and UTSW will insure training/education provided is appropriately provided within the clinics.* Conduct quality improvement for projects using methods such as rapid cycle improvements. *An opportunity for quality improvement can be the care management of specific patients identified by Family Medicine and PCIM clinic providers. Learning opportunities include face-to-face meetings with other providers in specialty care and the general internal medicine clinics*.

Milestones and Metrics

- P-2: Put in policies and systems to enhance patient access to medical home. Enhanced access to care is available through systems such as open scheduling
    - P-2.1: Performing Provider policies on medical home
- P-4: Develop staffing plan to expand primary care team roles; expand and redefine roles and responsibilities of primary care team members
    - P-4.1: Expanded primary care team member roles
    - P-4.2: Schedule training/educational opportunities for providers and staff on roles
- P-3: Reorganize staff into primary care teams responsible for coordination of patient care
    - P-3.1: Primary care team
- P-5: Determine appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases
    - P-5.1: Determine panel size
- P-14: Participate in face-to-face learning twice/year with providers and RHP to promote collaborative learning around shared or similar projects
    - P-13.1: Participate in semi-annual face-to-face meeting/seminar
- I-18: Obtain medical home recognition by nationally recognized agency (NCQA, etc.). Level will depend on practice baseline and accrediting agency.
    - I-18.1: Medical home recognition/ accreditation
- I-12: Based on criteria, improve number of eligible patients assigned to medical home
    - I-12.1: Number or percent of eligible patients assigned to medical homes where "eligible" is defined by Performing Provider
- ~~I~~**Community Need Assessment Identification Number**:

- *CN.4 – Health Care Capacity*
- *CN.9 – Need for care coordination for Chronic Disease*

How the Project significantly enhances an existing delivery system reform initiative

This initiative will provide the opportunity for the campus-based primary care clinics to prepare for and achieve NCQA designation as a PCMH. This will provide the opportunity for patients who may not utilize the COPC network to have a medical home.

Also this project provides an opportunity for Parkland and UT Southwestern to incorporate the medical home model into education/training of the future medical workforce.

The project has no related activities funded by U.S. Department of Health & Human Services.

Related Category 3 Outcome Measure(s)

OD-1: Primary Care and Chronic Disease Management

- IT-1.1: Third Next Available Appointment (Non-standalone Measure)
- IT-1.12: Diabetes care: Retinal eye exam – NQF 0055 (Non-standalone Measure)
- IT-1.13: Diabetes care: Foot exam – NQF 0056 (Non-standalone Measure)

Third Next Available Appointment. This measure is the industry standard measure for determining wait times for scheduled appointments.

Diabetes: Retinal Eye Exam. Diabetic retinopathy, one of the leading causes of blindness in adults, can be treated if detected and addressed in the early stages.[365] Medical teams will ensure patients with diabetes receive retinal eye exams as well as access to other services including ADA-certified diabetes self-management classes and services provided by certified diabetes educators/pharmacists.

Diabetes: Foot Exam. The lifetime risk of a person with diabetes developing a foot ulcer can be as high as 25%.[366] The most common set of causes that interact and result in foot ulcerations includes peripheral neuropathy, deformity, and trauma.[367] Identification of patients at risk of foot problems is the first step in preventing such complications and thus is a key measure.

Relationship to other Projects

Parkland is submitting a related project to enhance the medical home model in the COPC primary care system (127295703.2.1).

[365] American Optometric Association. *Diabetes is the leading cause of blindness among most adults*. 2012. http://www.aoa.org/x6814.xml

[366] *Singh N, Armstrong DG, Lipsky BA: Preventing foot ulcers in patients with diabetes. JAMA 293:217–228, 2005*

[367] Reiber GE, Vileikyte L, Boyko EJ, del Aguila M, Smith DG, Lavery LA, Boulton AJ: Causal pathways for incident lower-extremity ulcers in patients with diabetes from two settings. Diabetes Care 22:157–162, 1999

Category 4 Related Outcomes

- RD-5: ED Utilization
- RD-6: Initial Care Set of Health Care Quality Measures
    - Comprehensive Diabetes Care

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

Other related projects (Project Option 2.1) are being submitted by performing providers and include the following:

Performing Provider	Unique Project
Children's Medical Center	138910807.2.1
Medical City Dallas (HCA)	020943901.2.4
Methodist Dallas Medical Center	135032405.2.3
Tenet – Doctors Hospital at White Rock	094194002.2.1
Texas Health Presbyterian Dallas	020908201.2.3
UTSW – Faculty Practice Plan	126686802.2.1

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives appropriate to this project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. Parkland will also participate in any Outcome Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable improvement of the program and also provide information to other providers who may see the benefits of the program for ideas to improve their services. The exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 9.0 on a 9.0 scale. Influencing factors included:

- By advancing the medical home model even further, this project will yield the additional value with respect to the 20,000 annual visits in the Family Medicine clinic and 20,000 annual visits in the Primary Care Internal Medicine clinic
- Opportunities for partnership and collaboration with the many RHP 9 performing providers that are pursuing the medical home model
- Opportunities to increase capacity for specialty care services (some patients who would be better served in a medical home are currently utilizing specialty care services)

- Opportunities to decrease ED utilization for those better served in a medical home
- Sustainability in practice for Parkland's patient population
- Training of future workforce regarding medical home model concepts

The PCMH model has demonstrated benefits in terms of both quality and cost. A Geisinger Health System study indicated that the implementation of their advanced patient-centered medical home yielded from 6.7% to 10.8% reduction in PMPM observed cost relative to expected cost at 24 months from implementation.[368] Applying the cost reduction percentages to an average Medicaid PMPM extended by the number of medical home enrollees proposed by this project, the potential cost savings value that could be generated based on the medical home enrollment associated with this project aligns well with the project value.

Waiver Year	Proposed Parkland PCMH Enrollees	Average Medicaid Adult PMPM	Cost Savings Range	Potential Cost Savings
DY4	2,575	$371.60	6.7-10.8%	$ 769,323– $ 1,240,103
DY5	5,200	$371.60	6.7-10.8%	$ 1,553,585– $ 2,504,286
				$ 2,322,908– $ 3,744,389
Category 2 and associated Category 3 Total Project Value				$19,175,310

We realize the Geisinger model is a conservative approach to valuation for this project. A recent study shows 20% of the patients Parkland cared for in FY2012 have 15 or more comorbidities. These patients come through the Parkland Health & Hospital system many times and through many sites (ED, clinics, etc.) – and many search available access points until they find one. They have no connected home base where providers and staff can better coordinate their care. Of 290,000 unique patients, if 20% (58,000) could be targeted for enrollment in a medical home, that would alleviate significant burden to ~~all~~ access points at Parkland including the ED. Focused efforts on enrolling 5,000 who already utilize the campus-based primary care clinics is a strong start in this effort.

[368] Daniel D Maeng, PhD., Academy Health Annual Research Meeting, Reducing Long-Term Cost by Transforming Primary Care: Evidence From Geisinger's Medical Home Model, June 2012.

Unique Identifier: *127295703.2.11*	***Project Option****:* *2.1.1*	***Project Components:*** *2.1.1 (a-d)*	***Title:*** *Expand Medical Home Model – Family Medicine Clinic*
Parkland Health & Hospital System			*127295703*
Related Category 3 Outcome Measures	*127295703.3.40* *127295703.3.41* *127295703.3.42*	*3.IT-1.1* *3.IT-1.12* *3.IT-1.13*	*-Third next available appointment* *-Diabetes care: Retinal eye exam – NQF 0055* *-Diabetes care: Foot exam – NQF 0056*

Year 2 (10/1/2012 – 9/30/2013)	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] Put in policies and systems (scheduling) to enhance patient access to medical home. Metric 1 [P-2.1] Performing Provider policies on medical home Goal: Establish policies to meet medical home requirements Data Source: Policies/procedures Milestone 1 Estimated Incentive Payment: $1,967,859 **Milestone 2** [P-4] Develop staffing plan to expand primary care team roles; redefine roles/responsibilities of primary care team members Metric 2 [P-4.1]: Expanded primary care team member roles Metric 3 [P-4.2]: Schedule of training and educational opportunities for providers and staff on expanded roles Goal: Expand job descriptions of team members Data Source: Revised job descriptions	**Milestone 3** [P-3] Reorganize staff into primary care teams responsible for coordination of patient care Metric 4 [P-3.1] Primary care team Goal: Establish primary care teams Data Source: Documentation of staff assignments into care teams Milestone 3 Estimated Incentive Payment: ~~$2,012,652~~ $1,341,768 **Milestone 4** [P-5] Determine appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases. Metric 5 [P-5.1]: Determine panel size Data source: Panel size determination tool, patient registry, EMR, or needs assessment tool Milestone 4 Estimated Incentive Payment: ~~$2,012,652~~ $1,341,768 **Milestone 5** [P-13]: Review project	**Milestone 6** [I-12] Based on criteria, improve number of eligible patients assigned to medical home Metric 7 [I-12.1] Number or percent of eligible patients assigned to medical homes Baseline: No enrollees Goal: 2,575 patients Data Source: Practice management system, EMR or other documentation Milestone 6 Estimated Incentive Payment: $2,009,532 **Milestone 7** [I-18] Obtain medical home recognition by nationally recognized agency. Level will depend on practice baseline/accrediting agency Metric 8 [I-18.1] Medical home recognition/ accreditation for Family Medicine Goal: NCQA designation Data Source: Documentation of	**Milestone 8** [I-18] Obtain medical home recognition by nationally recognized agency. Level will depend on practice baseline/accrediting agency Metric 9 [I-18.1] Medical home recognition/ accreditation for PCIM clinic Goal: NCQA designation Data Source: Documentation of recognition/accreditation from nationally recognized agency Milestone 8 Estimated Incentive Payment: $1,622,603 **Milestone 9** [I-12] Based on criteria, improve number of eligible patients assigned to medical home Metric 10 [I-12.1] Number or percent of eligible patients assigned to medical homes Goal: Enroll 5,200 in medical home from Family Medicine and PCIM clinics

Unique Identifier: *127295703.2.11*	***Project Option****:* *2.1.1*	***Project Components:*** *2.1.1 (a-d)*	***Title:*** *Expand Medical Home Model – Family Medicine Clinic*	
Parkland Health & Hospital System				*127295703*
Related Category 3 Outcome Measures	*127295703.3.40* *127295703.3.41* *127295703.3.42*	*3.IT-1.1* *3.IT-1.12* *3.IT-1.13*	*-Third next available appointment* *-Diabetes care: Retinal eye exam – NQF 0055* *-Diabetes care: Foot exam – NQF 0056*	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2 Estimated Incentive Payment: $1,967,859	data and respond with new ideas, practices, tools, solutions <u>Metric 6</u> [P-13.1]: Number of new ideas, practices, solutions tested Data Source: Quarterly summary Goal: Increase number of new ideas, practices, solutions tested Data Source: Brief description of idea, practice, tool, or solution tested by each provider. Could be summarized at quarterly intervals Milestone 5 Estimated Incentive Payment (max amount): ~~$2,009,531~~ $1,341,768	recognition/accreditation from nationally recognized agency (eg NCQA) Milestone 7 Estimated Incentive Payment: $2,009,531	Data Source: Practice management system, EMR or other documentation Milestone 8 Estimated Incentive Payment: $1,622,603
Year 2 Estimated Milestone Bundle Amount: $3,935,718	**Year 3 Estimated Milestone Bundle Amount:** $4,025,304	**Year 4 Estimated Milestone Bundle Amount:** $4,019,063	**Year 5 Estimated Milestone Bundle Amount:** $3,245,206
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 15,225,291			

Project Option 2.8.4 – Apply Process Improvement Methodology to Improve Quality/ Efficiency – Enhance OPAT Program to reduce readmissions

Unique Project ID: 127295703.2.12

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Summary Description

Provider: Dallas County Hospital District d/b/a Parkland Health & Hospital System, "Parkland", is the public hospital and the largest major safety net hospital serving Dallas County and, in accordance with its mandate, furnishes medical aid and hospital care to the indigent and needy persons residing in the hospital district. As presented in the table below, Parkland is a critical provider in the region, particularly for the low income population. Parkland's payer mix includes 48% Charity/Self Pay, 31% Medicaid, 14% Medicare and 7% Commercial Insurance.

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Ambulatory Visits	1,031,311	n/a	n/a
- Community Centers	446,646		
- Women's Center	239,825		
- Subspecialty	344,840		

Intervention. This project will expand capacity of the Outpatient Parenteral Antimicrobial Therapy (OPAT) program. The OPAT program is a post-discharge program that allows patients receiving antibiotics in the hospital to be discharged in order to self-administer their medications at home, reducing lengths of stay on average 4-6 weeks per patient. Patients eligible for the OPAT program are provided education/training to administer their medications through PICC lines and are monitored by clinicians weekly in a dedicated post-discharge clinic.

Need for Project. At any given time, discharges are delayed for patients because they need medications administered through a PICC line for 4-6 weeks. For the indigent patients eligible to participate in the OPAT program, there is no post-acute alternative so they remain in the hospital to assure they receive medications, which increases costs for those hospital stays and

denies availability of that inpatient bed for other patients with more severe needs. Parkland's ED averages more than 500 patients per day of which many are placed on a wait list until beds open, requiring space and additional staff to hold patients in the ED or another unit until beds become available.

According to Dr. Kavita Bhavan (Clinical lead for the OPAT program) eligible OPAT patients can be trained to self-administer their medications at home can be discharged on average 28 days sooner. Based on the decreased ALOS, the OPAT program has the opportunity to expand to 600-650 patients which could potentially save the hospital $41,259,400 (average cost of $2,267 per day x average days saved 28 x 650 patients).

Target Population. The OPAT program currently provides care to indigent patients only who are eligible for discharge with a PICC line if they are able to self-administer medications at home. This population is targeted because of the lack of post-acute home care services available. In FY2012, 1,582 patients were identified as eligible for OPAT services but with current constraints, only 353 patients were enrolled (those 353 patients are seen once a week in the clinic for 6-8 weeks).

Of the OPAT patient population, more than 68% are diabetic, which is of particular interest. Parkland cares for more than 30,000 people who have been identified as diabetic or at risk for becoming diabetic. This patient population is the focus of several waiver projects with the intention of addressing this population's specific needs and improving their care throughout the health system (from primary to specialty care to inpatient and to post-acute care services).

Category 1 or 2 Expected Patient Benefits. This project seeks to increase program capacity to accept more patients into the program. Benefits include reduced lengths of stay, reduced 30-day readmission rates and improved infection rates at PICC line insertion site.

Category 3 Outcomes/Goal. Parkland defined the following FY16 outcomes:

While there are several improved outcomes including the ALOS per patient being reduced by 4-6 weeks, the outcome for this project is as follows:

- IT-3.12-Other – All Cause Readmission Rate for patients enrolled in OPAT program
  - Goal: Reduce All-Cause 30-day Readmissions Rate for patients enrolled in OPAT from 65% (FY11 baseline) to 20%

Project Description

Parkland Health & Hospital System will expand the OPAT program, which is an innovative and evidence-based intervention leading to significant decreases in lengths of hospital stays as well as improved outcomes for patients.

Parkland will expand the Outpatient Parenteral Antimicrobial Therapy (OPAT) program that provides indigent patients the self-management skills necessary to self-dispense antibiotics at

home through a PICC line. This process improvement project has been successful since its inception in 2009 in decreasing lengths of stay as well as readmissions for OPAT patients (the readmission rate for these patients has already been decreased from 65% to 27%).

Patients are identified as eligible to participate in the OPAT program if they are indigent and the treatment plan is for them to remain in the hospital simply to receive medications. Staff nurses who work with the OPAT team train patients who want to enroll in the OPAT program so they can self-administer their medications. Patients can then be discharged and monitored through the OPAT outpatient clinic on a weekly basis throughout their medication regiment. Clinic visits include the following: 1) Monitoring patient blood levels, 2) Insuring patient is getting the right amount of the antibiotic, 3) Providing fresh, sterile dressings over PICC line, and 4)Insuring there is no infection at PICC insertion site.

The intent of this project is to enhance/expand the Outpatient Parenteral Antimicrobial Therapy (OPAT) program through the following:

1) Increase staff resources (mid-level providers)

2) Continued process improvements such as:
- Development of training/education materials and tools for patients. The program team intends to develop training materials including DVDs developed in Spanish and English for ease of understanding how to self-manage post-discharge recovery and self-administer medications, etc.
- Preventing or slowing antimicrobial resistance through appropriate selection/dosing/route/duration of microbials
- Establish Antimicrobial Stewardship Team to :
    - Develop guidelines, protocols and/or restrictions for safe and appropriate use of antimicrobials
    - Evaluate targeted antimicrobial usage
    - Assure adherence to standards concerning use of antimicrobials
    - Review clinical interventions and adverse drug events secondary to antimicrobials
    - Educate medical staff on appropriate use of antimicrobials
- Enhance clinical decision support to monitor ADT, lab and pharmacy orders continuously and provide daily alerts for “inappropriate antimicrobial utilization”
- Identify possible improvements and efficiencies including cost savings. The program team determined they can also save the hospital as much as $450,000 per patient in drugs switching from Daptomycin (averaging $100 cost per day) to Vancomycin (averaging $10 cost per day).

3) Increase current OPAT clinic space on the main hospital campus

4) Implement innovative ideas such as providing OPAT services at the primary care clinics so patients can stay in their communities for weekly follow up visits

Goals and Relationship to Regional Goals

The goal of this project is to expand/enhance the OPAT program and increase the volume of patients who could be enrolled in the program, which will provide those patients with the skills to self-manage their medications at home and will provide significant reductions in LOS (approximately 4-6 weeks per patient). Since its inception, this program has proven to not only decrease the ALOS for eligible patients, but also decrease readmissions and decrease PICC line infection rates. The outcomes for this project are to further decrease he readmission rate and the average length of stay (ALOS) for enrolled patients.

Regional goals include improved access to care, improved care coordination and management and improved provider performance and outcomes. The OPAT program is a foundational program for all of these goals. It provides access to the more appropriate setting of care for indigent patients who previously remained in the hospital only to receive necessary medications that would not be available to them if they were discharged. Patients attend weekly follow up visits in the OPAT clinic.

Challenges

A key challenge for this indigent population has been lack of access to post-acute services. That has created a backlog for Parkland in discharging patients who still require post-acute services such as home health, to administer medications. This backlog has created a domino effect for Parkland. Because these patients have no post-acute services available, they remain in the hospital (to insure they receive medications) which then constrains availability of inpatient beds for patients held in the ED or observation units, all of which compounds the problem of providing appropriate care to patients in an appropriate setting. While Parkland alone cannot resolve the post-acute system constraints, project 127295703.2.5 has been submitted to review options for post-acute care that may lessen the burden for patients with no current access to such services.

Another key challenge has been that the OPAT program expanded faster than anticipated and is now at capacity with 5 times the demand of current volumes. With expansion of the OPAT program including increasing staff and space, more patients could be enrolled in the program.

5-Year Expected Outcome for Provider and Patients

The five year goals for the project include:

- Increased volume of patients who could be discharged from the hospital sooner
- Reduced average length of stay for those who can be enrolled in the OPAT program

- Reduced number of 30-day readmissions for OPAT patients
- Reduced site of insertion infection rates
- Reduced cost for medications

Starting Point/Baseline

In FY2012, the OPAT clinic monitored 353 patients once a week for 6-8 weeks. The FY2011 baseline for readmissions of OPAT patients was 65%.

Rationale

The OPAT program, specific to Parkland's indigent population is the first program of its kind in the United States. While this intervention has been cited by several studies (in the U.S., Canada, Ireland, etc.), the patient populations served have been insured and/or relatively small in comparison. As Parkland's program continues to expand with improved outcomes, it will set the national standard for this type of program for patients with no financial means and access to care after discharge.

OPAT programs are evolving while research has been done to prove it can be a safe and feasible strategy. Oxford Ratcliffe Hospitals performed a retrospective review of its OPAT program over 13 years. This review of 2,000 patients determined that this program not only can decrease hospital costs and increase patient satisfaction, but is safe and practical when clinical teams supervise eligible patients to self-administer their medications at home.[369]

Prior to Parkland's OPAT clinic's existence, patients discharged on Outpatient Antibiotic Therapy were followed in various settings, and had frequent emergency room (ER) visits and readmissions related to their therapy. This clinic has also decreased the inpatient days anywhere from 21 to 35 days (average of 28 days) accrued from inpatients only needing IV antibiotics. At an average daily cost of $2,267 for a patient at Parkland, this program provides an average cost savings of $63,476 per patient and with the current volume of 353 patients, that's a cost savings of approximately $22,407,028.

Parkland also intends to standardize care throughout the continuum of patient experience from admission, education to patient, to transition of care from inpatient to OPAT clinic and home health care as applicable, which is currently nonexistent. Research validates that patients that come to the OPAT clinic have better outcomes than even those that are contracted through different home health agencies in the community. This can lend itself to sharing of best practices in learning collaboratives with post-acute providers and medical home providers. This project aligns well with other Parkland projects including those of performance and process improvements, care transitions, patient navigation, and implementing a cost system to determine benefits of post-acute alternatives.

[369] Oxford Ratcliffe Hospitals NHS Trust, et al. "Outpatient Parenteral Antimicrobial Therapy (OPAT): Is it Safe for Selected Patients to Self-Administer at Home? A Retrospective Analysis of a Large Cohort over 13 Years." Oxford University Press on behalf of the British Society for Antimicrobial Chemotherarpy. May 17, 2007.

Project Components

There are no required components of Project Option 2.8.4 - Implement an innovative and evidence based intervention that will lead to reductions in 30-day readmissions for providers that have demonstrated need/unsatisfactory performance in this area. However, though not required, we intend to meet several components under Project Option 2.8.1:

- Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture. *Staff education and training are essential to insure patients are appropriately trained to self-manage their medication administration at home. OPAT program leaders are developing educational tools and expanding the training/education for clinicians. Educational tools and materials will also be developed for patients to take home to assist them during their treatment.*
- Define key safety, quality, and efficiency performance measures and develop a system for continuous data collection, analysis, and dissemination of performance on these measures (i.e. weekly or monthly dashboard). *Data collection, analysis and dissemination of performance are currently available and safety, quality and efficiency performance measures are reported.*
- Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement. *Process maps, models, protocols are being implemented.*
- Implement software to integrate workflows & provide real-time performance feedback. *Parkland is undertaking many initiatives to improve data systems in the clinics*
- Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change processes based on the results of key performance indicators. *The impact of the program is regularly monitored and appropriate changes are made as information and results warrant.*

In addition to the above, the continuous quality improvement milestone [P-15] to participate in face-to-face learning twice per year with providers and RHP to promote collaborative learning around shared or similar projects will be implemented. The program leadership has been very receptive to sharing outcomes and program information with other providers.

Milestones and Metrics

- P-3: Compare & analyze clinical/quality data and identify at least one area for improvement
    - P-X: Analysis and identification of areas for improvement
- P-X1: Engage stakeholders, identify resources and potential partnerships and develop intervention plan (including implementation, evaluation and sustainability)
    - P-X1.1: Submission of business plan and related documentation

- P-8: Train/educate providers/ staff in process improvement
    - P-8.1: Number of providers/ staff trained/ educated
    - P-8.2: Number of trainings held
- P-12: Report findings and learnings
    - P-12.1: Final report summary
- P-15: Participate in face-to-face learning twice/year with providers and RHP to promote collaborative learning around shared or similar projects
    - P-13.1: Participate in semi-annual face-to-face meeting/seminar
- I-13: Progress toward target/goal
    - I-Y.1: Number or percent of cases that meet target/goal
- I-16: Improve quality/efficiency using innovative project option
    - I-16.2: Improved 30-day readmissions rate for patients sent home with PICC line

Unique Community Need Identification Numbers the Project Addresses

- *CN.11 – Patient Safety and Quality*
- *CN.12 – ED Utilization and Readmissions*

How the Project significantly enhances an existing delivery system reform initiative

The OPAT program expansion significantly reduces average length of stay, decreases infection rates and decreases readmission rates and ED visits as evidenced by the initial decrease in 2010-2011 and currently trending down. Eligible patients can be discharged weeks earlier and trained to self-administer medications at home with appropriate follow up. Such a substantial reduction in the length of stay (averaging 28 inpatient days per patient) has benefits for the patient as well as for the hospital, which are addressed above.

The project has no related activities funded by U.S. Department of Health & Human Services.

Related Category 3 Outcome Measure(s)

OD-3: Potentially Preventable Readmissions

- IT-3.12: Other – 30-day Readmission Rate: Number of readmissions for patients 18+ years and older for any cause from index admission when discharged with PICC line to self-administer medications

When patients are discharged with a PICC line, the opportunity of improving their outcomes and/or reducing their length of stay is only viable if they are not readmitted due to a health issue related to self-management of their medications.

Relationship to Other Projects

Each project submitted by Parkland addresses a component of the continuum of care and are all aligned to balance the continuum so not to place undue burden on one site of care within the health system. This project addresses improvements in the hospital (decreased LOS) and in the post-acute care setting (discharging to an appropriate level of care).

Specifically, the clinical outcome for this project, 30-day readmission rate, is also being addressed in the following projects:

127295703.1.4	Implement chronic care patient registry*
127295703.1.10	Enhance performance improvement and reporting capacity
127295703.2.4	Expand chronic care model*
127295703.2.7	Implement patient navigation program
127295703.2.9	Implement care transitions program

**More than 68% of OPAT patients are diabetic, and the project for expanding the chronic care management model is targeting diabetic patients.*

Category 4 Related Outcomes

- RD-2: Potentially Preventable Readmissions
- RD-5: Emergency Department

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

There are no related projects being submitted through the RHP 9 plan since this is an innovative program specific to Parkland's patient population as indigent patients with no means for post-discharge care. However, the physician leader for this program is already sharing information and is submitting a paper for publication regarding the program's success.

We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV - Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Parkland adopted the RHP 9 global method for project valuation supplemented by comparisons with like projects within and outside the region. Each project was evaluated with respect to its transformational impact, population served, project size and complexity, alignment with the

community needs, cost avoidance impact, sustainability and partnership collaboration. This project had a weighted average score of 8.15 on a 9.0 scale. Influencing factors include:

- Transformational impact for patient care for the indigent population
- Patient education for self-management of care
- Opportunity for increased bed capacity for other patients waiting
- Avoidable costs of delaying discharge for patients who only require medications that could administered post-discharge

According to Dr. Kavita Bhavan (Clinical lead for the OPAT program) eligible OPAT patients can be trained to self-administer their medications at home can be discharged on average 28 days sooner. Based on the decreased ALOS, the OPAT program has the opportunity to expand to 600-650 patients which could potentially save the hospital $41,259,400 (average cost of $2267 per day x average days saved 28 x 650 patients).

Unique Identifier: *127295703.2.12*	***Project Option:*** *2.8.4*	***Project Components:*** NA	***Title:*** *Apply Process Improvement Methodology to Improve Quality/Efficiency through the Outpatient Parenteral Antimicrobial Therapy (OPAT) program*	
Parkland Health & Hospital System				*127295703*
Related Category 3 Outcome Measures:	*127295703.3.43*	*3.IT-3.12*	*Other: 30-day Readmission Rate for Patients discharged with PICC line to administer antibiotics*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Compare and analyze clinical/quality data and identify at least one area for improvement Metric 1 [P-3.1]: Analysis and identification of areas for improvement Data Source: Analysis Milestone 1 Estimated Incentive Payment (max amount): $3,356,936 **Milestone 2** [P-X1]: Engage stakeholders, identify resources and potential partnerships and develop intervention plan (implementation, evaluation and sustainability) Metric 2 [P-X1.1]: Submission of business plan and related documentation Data Source: Business Plan Milestone 2 Estimated Incentive Payment (max amount): $3,356,936	**Milestone 3** [P-8]: Train/educate providers/ staff in process improvement Metric 4 [P-8.2]: Number trainings held Data Source: Curriculum or other training schedules/materials Milestone 3 Estimated Incentive Payment (max amount): $3,433,347 **Milestone 4** [P-12]: Report findings and learnings Metric 5 [P-12.1]: Final report summary Submission of report Data Source: All data sources used for process improvement events Milestone 4 Estimated Incentive Payment (max amount): $3,433,347	**Milestone 5** [P-15]: Participate in face-to-face learning twice/year with providers and RHP to promote collaborative learning around shared or similar projects Metric 6 [P-15.1]: Participate in semi-annual face-to-face meeting/seminar Data Source: Documentation of meetings including meeting agendas, slides, meeting notes Milestone 5 Estimated Incentive Payment (max amount): $3,428,024 **Milestone 6** [I-13] Progress toward target/goal Metric 7 [I-13.1]: Number or percent of cases (OPAT patients) Baseline: 353 OPAT patients (1,582 eligible patients) Goal: 450 OPAT patients Data Source: Statistics Report Milestone 6 Estimated Incentive Payment (max amount): $3,428,024	**Milestone 7** [I-16] Improve quality/efficiency using innovative project option. Metric 8 [I-16.1]: Achieve X% improvement for minimum of X key performance indicators (LOS, discharge process times, etc.) Goal: 600 OPAT patients Data Source: OPAT Quality & Statistics Report Milestone 7 Estimated Incentive Payment (max amount): $5,535,940

Unique Identifier: *127295703.2.12*	***Project Option:*** *2.8.4*	***Project Components:*** NA	***Title:*** *Apply Process Improvement Methodology to Improve Quality/Efficiency through the Outpatient Parenteral Antimicrobial Therapy (OPAT) program*	
Parkland Health & Hospital System				*127295703*
Related Category 3 Outcome Measures:	*127295703.3.43*	*3.IT-3.12*	*Other: 30-day Readmission Rate for Patients discharged with PICC line to administer antibiotics*	

Year 2 (10/1/2012 – 9/30/2013)	**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: $ 6,713,872	**Year 3 Estimated Milestone Bundle Amount:** $6,866,694	**Year 4 Estimated Milestone Bundle Amount:** $6,856,048	**Year 5 Estimated Milestone Bundle Amount:** $5,535,940
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):*			**$25,972,554**

Project Option 2.6.2 – Establish Self-Management Programs and Wellness Using Evidenced-Based Designs – Faith Community Health/Nursing Program

Unique Project ID: 020908201.2.2
Performing Provider Name/TPI: Texas Health Presbyterian Hospital Dallas/020908201

Provider: Texas Health Presbyterian Hospital Dallas, part of the Texas Health Resource system, serves a 621.5 square mile area and a population of approximately 2,054,356 people.

Intervention(s): This project will partner with faith communities in the service area to design self-management wellness programs using evidence-based practices.

Need for the project: This program has limited funding and staff. We need more nurses and Faith Community Health Workers to reach a greater number of patients.

Target population: The target population is individuals in the community that may not have access to primary care, are unlikely to seek primary care, and suffer from high blood pressure or diabetes that is unmanaged.

Category 1 expected patient benefits: This project seeks to provide care in a non-traditional setting that will engage the community in taking charge of their healthcare.

Category 3 outcomes: IT-1.7 our goal is to increase the number of people 18-75 years old with controlled high blood pressure by 15%

IT-1.11 our goal is to increase the number of people 18-75 years old with diabetes (type 1 and type 2) with controlled blood pressure by 15%.

Project Description

Our Faith Community Health/Nursing (FCH/N) program will partner with faith communities (congregations) in the Texas Health Presbyterian Hospital of Dallas service area to design self-management wellness programs using evidenced-based practices. The FCH/N program will train nurses (Faith Community Nurses) and lay workers (Faith Community Health Workers) to create supportive environments that encourages congregants to take an active role in managing their chronic conditions.

Currently, there are no hospitals in our region establishing an evidenced-based self-management program that promotes health and wellness. This program is designed to improve the health of the whole person (body, mind and spirit) and is a much needed program for RHP-9 thus affecting access to health care services and chronic condition management needs of this population.

The FCH/N program will consist of a Program Director of Faith Community Health, A Faith Community Nursing Coordinator and Lay Health Educators. Faith Community Nurses and Faith Community Health Workers will be trained to implement culturally and linguistically appropriate evidenced-based self-management programs, health education classes, and support groups within their congregational setting. The International Parish Nurse Resource Center Curriculum will be utilized for training FCNs. A curriculum developed in house will be utilized for training FCHWs. Initially, a congregational health needs assessment will identify the top 5 priorities. The Henry Ford Macomb Hospitals' FCN/Health Ministry Reporting and Documentation Tool will track project progress. This tool demonstrates evidence of the importance of utilizing FCNs and FCHWs in the congregational setting[370] and allows for the reporting of community benefit activities.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals:

The goal of this project is to develop and implement an innovative self-management FCH/N program with a particular focus on controlling high blood pressure among congregants with and without diabetes. Faith Community Nurses and Faith Community Health workers will help to create a supportive environment for congregants to learn how to self-manage their disease. They may also assist in connecting congregants to resources within the community.

Utilizing the Faith Community Nursing model, our goals are to:

(1) Promote health and wellness,
(2) Create or expand on an environment within the congregational setting to educate, share and discuss health and wellness and
(3) To improve health outcomes of the people in the faith communities living with chronic disease.

A major goal of the region is to reduce chronic disease and emergency department usage and readmissions. Education and controlled self-management of chronic disease will decrease the need to utilize emergency services for primary care.

Challenges

Approximately 33% of the US population and Texas has high blood pressure[371] and approximately 50% of this cohort controls their high blood pressure[372]. One of the Healthy

[370] Brown, AR., Giacona, M., Stockwell MA. Faith community nursing demonstrates good stewardship of community benefit dollars through cost savings and cost avoidance. Family & Community Health. 2009; 32(4): 330-338.
[371] Centers for Disease Control and Prevention (2012). Hypertension. Retrieved from: http://www.cdc.gov/nchs/fastats/hyprtens.htm

People 2020 objectives is to increase the proportion of adults who have their high blood pressure under control[373]. Another goal of Healthy People 2020 is to increase the proportion of the population with diagnosed diabetes whose blood pressure is under control[374]. In Texas, 67% of adults with diabetes have high blood pressure[375] and according to the Health indicators Warehouse approximately 51% of patients with diabetes[376] have controlled high blood pressure. The evidenced-based self-management wellness program will be made available to all members of the congregation; however, it will benefit low-income, Medicaid and uninsured populations. Faith Communities are made up of different races and ethnicities, ages, genders, uninsured, insured, Medicaid and low-income people. A systematic review of published literature suggested that health programs in faith-based organizations were determined to be effective[377]. These culturally and linguistically appropriate programs will be delivered utilizing the FCHW and the FCN within the congregational setting.

5-Year Expected Outcome for Provider and Patients

Our five-year goal is to increase the participation rate from 11 to at least 40 congregations that develop Faith Community Health/Nursing and establish evidenced-based self-management wellness programs.

Starting Point/Baseline

As of 2009, the FCH/N program at THD trained approximately 12 FCNs who served in 7 different faith communities within the service area. Faith Community Nurses implemented programs such as blood pressure screenings, hand hygiene education, CPR training, etc. Unfortunately, due to the lack of resources and support, evidenced-based self-management programs were not able to be implemented. In 2012, a Program Director of Faith Community Health was hired to help launch a pilot program, "Faith Community Health," in collaboration with Faith Community Nursing to improve the health of the people within the congregational setting. This new pilot program was launched in September 2012 and has since trained over 15 Faith Community Health Workers from 7 different Faith Communities. Currently, we are in partnership with 11 congregations that vary in size. In total, these congregations make up approximately 25,000 people. We plan to roll this model out to more congregations in Dallas County.

Rationale

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[372] Centers for Disease Control and Prevention (2012). High Blood Pressure Facts. Retrieved from http://www.cdc.gov/bloodpressure/facts.htm

[373] U.S. Department of Health and Human Services (2012). Healthy People.gov [2020 topics and objectives]. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=21

[374] U.S. Department of Health and Human Services (2012). Healthy People.gov [2020 topics and objectives]. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=8

[375] Nelson, P. Hypertension in diabetes: where should the millimeters of mercury be? Pharmacotherapy Education and Research Center – UT Health Science Center at San Antonio. 2011: 1-24.

[376] National Health Indicators Warehouse (2010). Blood pressure undercontrol—persons with diabetes. Retrieved from: http://healthindicators.gov/Indicators/Blood-pressure-under-control--persons-with-diabetes-percent_560/National_0/Profile/Data

[377] DeHaven, MJ., Hunter, IB., Wilder, L., Walton, JW., Berry, J. Health Programs in Faith-Based Organizations: Are They Effective? American Journal of Public Health. 2004; 94(6): 1030-1034.

The FCH/N was selected to enhance access and care delivery infrastructure by extending the continuum of care model. The "Continuum of Care" can best be understood by the stages of care provided to an individual. These stages are pre-acute (i.e., wellness and prevention) acute care (i.e., hospital setting); post-acute care (i.e., manage health improvement). The FCH/N program will expand the delivery of care by engaging physicians, nurses and healthcare professionals to provide health education and health screenings in the faith communities.

Project Components

There are no core requirements

Unique community need identification numbers the project addresses

- CN.8: Chronic Disease
- CN.11: Emergency Department Usage and Readmissions

How the project significantly enhances an existing delivery system reform initiative

As a hospital THD provides patient care services but this initiative will provide health prevention and promotion services within the community. We have not received any federal funding for this program.

Related Category 3 Outcome Measures and Rationale

- IT – 1.7 Controlling High Blood Pressure (stand – alone)
  By the end of the waiver, our goal is to increase the number of people 18 – 75 years old with controlled high blood pressure (<140/90 mm Hg) by 15%. In DY2, we will establish the baseline for this rate.

- IT – 1.11 Diabetes care: BP control (<140/80 mm Hg)
  By the end of the waiver, our goal is increase the number of people 18 – 75 years old with diabetes (type 1 and type 2) with controlled blood pressure (<140/80 mm Hg) by 15%.

Reasons/rationale for selecting the outcome measures:

(This validated, evidence-based rationale is for outcome 1 & 2)
Assuming Texas health status to approximate the national average of people who have high blood pressure, then it can be estimated that 33% of people in Texas have hypertension[378]. More specifically, Dallas county patients who came to the ER with chest pain as a diagnosis,

[378] Centers for Disease Control and Prevention (2012). Hypertension. Retrieved from: http://www.cdc.gov/nchs/fastats/hyprtens.htm

21% to 25% had a comorbidity of diabetes[379]. Lorig and colleagues (1999) showed evidence that chronic disease self-management program can improve health behaviors and health status, while also reducing hospitalizations and days of hospitalization[380].

Relationship to other Projects

This project is related to the Continuing Care Clinic ((020908201.1.1). The goal of the project is to reduce admissions and lower the overall cost of healthcare to the individual and system. These projects will work in tandem with each other to provide access to care unfunded patients.

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

Children's Medical Center is also submitting a project related to health promotion programs (138910807.2.2).

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable use to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology: For every participant, $1,200 in cost is saved by the healthcare system[381]. Healthcare costs are calculated by multiplying $1,200 by the total individuals affected.

Rationale/Justification: Outcome improvement targets are dependent on the target population served (e.g. # of participants) and size.

[379] Collins, S. Regional Health Partnership 9: Community Health Needs Assessment Report [Draft]. Retrieved from http://www.healthyntexas.org/javascript/htmleditor/uploads/Final_1115_Needs_Assessment_Report_5.22.12.pdf
[380] Lorig, KR., Sobel, DS., Stewart, AL., Brown, BW., Bandura, A. Ritter, P., Gonzalez, VM., Laurent, DD., Holman, HR. Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalizations: A Randomized Trial. Medical Care. 1999; 37(1): 5-14.
[381] Texas Department of State Health Services with 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

Unique Identifier *020908201.2.2*	***RHP PP Reference Number:*** *2.6.2*	***Project Components:*** *NA*	***Title:*** *Implement Evidence-based Health Promotion Programs*	
Texas Health Presbyterian Hospital Dallas				*020908201*
Related Category 3 Outcome Measure(s):	*020908201.3.6* *020908201.3.7*	*IT-1.7* *IT-1.11*	*Controlling High Blood Pressure* *Diabetes care: BP control (<140/80mm 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)**
Milestone 1 [P-2]: Development of evidenced-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community. **Metric** 1 [P-3.1]: Documentation of the innovational strategy plan **Baseline/Goal:** By the end of year 2, develop 1 evidenced-based project for targeted population. **Data source: Program Documents** Milestone 1 Estimated Incentive Payment *(maximum amount):* $313,205 **Milestone 2** [P-3]: Implement, document and test an evidenced-based innovative project for targeted population **Metric 1** [P-3.1]**:** Document implementation strategy and testing outcomes **Baseline/Goal:** By the end of year 2, implement 1 evidenced-based project for targeted population	**Milestone 3** [P-4]: Execution of a learning and diffusion strategy for testing spread and sustainability of best practices and lessons learned. **Metric 1** [P-4.1]: Document learning and diffusion strategic plan. **Baseline/Goal:** By the end of year 3, present learning and diffusion strategy at 2 meetings within the THR system. **Data Source:** Program Documents Milestone 3 Estimated Incentive Payment: $303,250 **Milestone 4** [P-5]: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned **Metric 1** [P-5.1]: Document evaluative process, tools and analytics Baseline/Goal: Milestone 4 Estimated Incentive Payment: $303,251	**Milestone 5** [I-8]: Increase access to health promotion programs and activities using innovative project option **Metric 1** [I-8.1]: Increase percentage of target population reached Goal: 30 congregations **Data Source:** Program Documents Milestone 5 Estimated Incentive Payment: $639,677	**Milestone 6** [I-8]: Increase access to health promotion programs and activities using innovative project option **Metric 1** [I-8.1]: Increase percentage of target population reached Goal: 40 congregations **Data Source:** Program Documents Milestone 6 Estimated Incentive Payment: $516,509

Unique Identifier *020908201.2.2*	***RHP PP Reference Number:*** *2.6.2*	***Project Components:*** *NA*	***Title:*** *Implement Evidence-based Health Promotion Programs*	
Texas Health Presbyterian Hospital Dallas				*020908201*
Related Category 3	*020908201.3.6*	*IT-1.7*	*Controlling High Blood Pressure*	
Outcome Measure(s):	*020908201.3.7*	*IT-1.11*	*Diabetes care: BP control (<140/80mm 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)**
Data Source: Program Documents Milestone 2 Estimated Incentive Payment: $313,206			
Year 2 Estimated Milestone Bundle Amount: $626,411*	Year 3 Estimated Milestone Bundle Amount: $606,501*	Year 4 Estimated Milestone Bundle Amount: $639,677*	Year 5 Estimated Milestone Bundle Amount: $516,509*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $2,389,097			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Project Option -2.1.2 Collaborate with an affiliated Patient-Centered Medical Home to integrate care management and coordination for shared, high-risk patients

Unique Project ID: 020908201.2.3 (Pass 2)
Performing Provider Name/TPI: Texas Health Presbyterian Hospital Dallas/020908201

Project Description

Healing Hands Ministries is a grassroots, volunteer-driven community based organization that provides medical and dental care to patients in Dallas County. The clinic is a beacon of hope providing reliable, efficient, low-cost medical and dental care to the needy – in a nurturing, welcoming environment. Texas Health Resources, Texas Health Presbyterian Hospital Dallas (THD), and Texas Health Physician Group fostered a relationship with Healing Hands through Dallas County Medical Society's Project Access Dallas (PAD). Dallas County Medical Society determined in December 2012 to discontinue Project Access Dallas, this project will provide care for those patients previously cared for through PAD who utilized THD's services and patients Healing Hands cares for that were not previously enrolled in PAD.

This project will build upon the existing resources and relationships THD has with Healing Hands and will focus on connecting patients to care by creating a coordinated defined process of referral from THD to Healing Hands. Healing Hands will become the primary care "home" for the referred patients. It is important for these patients to be assigned to a "home" with a health care team who provides services based on a patient's unique health needs, effectively coordinates the patient's care across inpatient and outpatient settings and proactively provides preventive, primary, routine and chronic care. Also, the plan creates financial incentives and opportunities for collaboration between THD and Healing Hands to provide care to a "cohort" of uninsured/underinsured residents in a performing provider service area that would otherwise not have access to quality care and improved health outcomes.

Collaboration

This project is being proposed through a collaboration agreement as set forth below.

Collaborators	DY2	DY3	DY4	DY5	Total
Texas Health Presbyterian Hospital Denton	436,706	502,853	534,560	578,352	2,052,471
Texas Health Presbyterian Hospital Kaufman	314,984	362,694	385,564	417,150	1,480,392
Parkland Memorial Hospital	1,496,906	1,746,438	1,842,667	1,961,679	7,047,690
Total Through Collaboration	**2,248,596**	**2,611,985**	**2,762,791**	**2,957,181**	**10,580,553**

Project / Collaboration	DY2	DY3	DY4	DY5	Total
Category 2 Project Value	2,767,898	2,679,921	2,826,514	2,282,278	10,556,611
Related Category 3 Projects Value	358,198	566,180	605,682	1,448,368	2,978,428
Total Project Value	**3,126,096**	**3,246,101**	**3,432,196**	**3,730,646**	**13,535,039**

The collaboration involves the transfer of Pass 2 allocated dollars from two intra-system hospitals to the Texas Health Presbyterian Dallas Hospital. This funding is supplemented by the transfer of Pass 2 allocation from Parkland Memorial Hospital (public entity) to the performing provider (private entity). The combined project value for this project exceeds the funding provided by the collaborating entities.

Pooling the Pass 2 allocation provided sufficient funds to support this larger project to be performed by Texas Health Presbyterian Hospital Dallas. All parties join together in this collaboration with the belief that the goals of this project are valuable and will contribute to regional transformation.

Goals and Relationship to Regional Goal

A major goal of the region is to provide improved access to coordinated primary and specialty care. This project would contribute to achieving that goal by implementing a collaborative across multiple performing providers committed to identifying eligible uninsured residents' access to a patient centered medical home.

The five year goal of Healing Hands Ministries and Texas Health Dallas are:

- Implement a comprehensive, multidisciplinary intervention to address the needs of the shared, high-risk patients; direct referral process for assured connection to care.
- Evaluate the success of the intervention by decreasing ED and inpatient hospitalization by shared, high-risk patients and use this data in rapid-cycle improvement to improve the intervention.
- Improve data exchange between Texas Health Dallas and Healing Hands Ministries
- Develop actionable health information analytical capability for reporting provider performance, patient risk stratification and population management, leverage the intellectual property of providers in achieving qualitative and quantitative improvement in care the uninsured working poor.

Challenges/Issues:

Providing access to this high risk population has many challenges. This population experiences numerous barriers such as learning literacy issues, language barriers, affording medications, keeping appointment when they are not connected to a medical home. Cultural issues can make changing behaviors difficult. This project aims to expand access to this population by expanding THD's relationship with Healing Hands to increase access to care as a designated medical home to this high risk patient population. This measure creates efficiency and reduces the cost of providing care to this population by implementing strategies to assure this population is connected to care. Options for the uninsured to access coordinated and comprehensive health care are limited. The project aims to provide patients with additional high quality services that are culturally sensitive while proving accountable and measurable outcomes which will propagate an improvement of their health care experience. The major challenge we face is determining the patient's referral source when they present to the Emergency Department or are admitted to the hospital. A formal referral process will be created with a unique patient identifier that will make tracking this vulnerable population easier for Texas Health Presbyterian and Healing Hands.

Starting Baseline

Healing Hands Ministries (HHM) and THD currently care for a population of about 968 patients. THD will work with Healing Hands to care for these patients. THD will provide diagnostic and lab services, outpatient, and inpatient services as needed.

Rationale

As indicated in the Dallas Fort Worth Hospital Council's RHP 9 Community Needs Assessment, there is a strong demand for primary and specialty care services. The demand for hospital, primary care and specialty care services exceeds the supply of available medical physicians in the hospital's service area, thus limiting health care access for low level management or specialized treatment for prevalent health conditions. Many primary care physicians accept a limited number of the Medicaid/Uninsured population due to the lack of coordination of care and access to appropriate ancillary services. Consequently, many residents seek primary care treatment in emergency care settings resulting in increased healthcare costs and higher volumes of preventable and avoidable cases populating emergency department waiting rooms. Thus, improved/continued support to physicians, Healing Hands Ministries and Texas Health Dallas through the exchange of information, coordination of services can have a significant impact on the uninsured ability to access care and improve outcomes.

Project Core Components

A. Improve data exchange between hospitals and affiliated medical home sites.

B. Develop best practices plan to eliminate gaps in the readiness assessment.

C. Hire and train team members to create multidisciplinary teams including social workers, health coaches, care managers, and nurses with a diverse skill set that can meet the needs of the shared, high-risk patients

D. Implement a comprehensive, multidisciplinary intervention to address the needs of the shared, high-risk patients

E. Evaluate the success of the intervention at decreasing ED and inpatient hospitalization by shared, high-risk patients and use this data in rapid-cycle improvement to improve the intervention.

F. 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.

Reason for selecting milestones/metrics

Our milestones measure an increased population receiving care through a direct referral to a medical home model of care: (1) we are establishing and implementing medical home assignment criteria, (2) we are determining the appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases. (3) we are increasing the number of eligible patients assigned to a medical home, (4) we are increasing the number of new patients assigned to medical homes that are connected to a medical visit within 60 – 120 days and (5) we are documenting medical home recognition/accreditation of community/charity clinic by a nationally recognized agency (e.g. NCQA). This demonstrates a means to provide quality care while be held to a recognized standard. (6) we are providing access to patients that otherwise would not have the ability to receive care while managing complex high risk health issues with a more coordinated approach utilizing the skills of a multidisciplinary team. These relationships demonstrate the ability to positively impact high risk patient health outcomes.

Community Needs Assessment Identification Number

- CN.3 Healthcare Capacity
- CN.8 Chronic Disease

Describe how the project represents a new initiative or significantly enhances an existing delivery system reform initiative

This project is new for Texas Health Dallas and improves the relationship between the hospital and Healing Hands Ministries through a continued agreement to care for uninsured patients and improve access to primary and specialty care.

Related Category 3 Outcome Measures

IT- 11.5 All-Cause Admission Rate for Chronically-Ill patients. This measure will demonstrate the importance of assigning low income uninsured residents to a medical home. By doing so, this will decrease the admission rate for chronically ill (diagnosis of Diabetes, CHF, Hypertension, COPD, or Asthma) Healing Hands patients post enrollment.

Relationship to other Projects

This project is related to the Continuing Care Clinic project (020908201.1.1.2) and the Faith Community Nursing/Health Worker Project (020908201.2.6). Both of these projects goals are to reduce admissions and lower the overall cost of healthcare to the individual and system. These projects will work in tandem with each other to provide access to patients.

Relationship to Other Performing Providers Projects in the Region

This project is not directly related to any other project in the region with a 2.1.2 category.

Project Valuation

Approach/Methodology: For every inpatient readmission avoided, $7,724 in cost is saved by the healthcare system[382]. Healthcare costs are calculated by multiplying $7,724 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

Rationale/Justification: Inpatient readmissions outcome improvement targets are dependent on the target population served (e.g. aging populations will have increased admissions due to higher incidence rates), size (e.g. if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable readmissions (e.g. keeping lower acuity patients under observation instead of admitting them). Outcome improvement targets are dependent on the target population served (e.g. the number of new enrollees each year).

[382] Based on the average avoided inpatient admission cost for Diabetes, CHF, Hypertension, COPD, or Asthma, and assumes a cost-to-revenue of 30%. Texas Department of State Health Services.

020908201.2.3	*2.1.2*	*2.1.2 (A-F)*	*ENHANCE MEDICAL HOMES - HEALING HANDS MINISTRIES*	
Texas Health Presbyterian Hospital Dallas				*020908201*
Related Category 3 Outcome Measure(s)	**020908201.3.8**	*3.IT-11.5* *3.IT-5.1*	*Addressing Health Disparities in Minority Populations: All-Cause Admission Rate for Chronically-Ill patients- as defined by performing provider Cost of Care*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-6]: Establish/ implement criteria for medical home assignment **Metric 1: P-6.1:** Medical home assignment criteria Data source: Submission of medical home assignment criteria Milestone 1 Estimated Incentive Payment: $691,974 **Milestone 2 [P-5]]** Determine the appropriate panel size69 for primary care provider teams, potentially based on staff capacity, demographics, and diseases. Empanelment should be based on the following principles: Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis; Assess practice supply and demand, and balance patient load accordingly; Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status,	**Milestone 5: [P-5]** Determine the appropriate panel size69 for primary care provider teams, potentially based on staff capacity, demographics, and diseases. Empanelment should be based on the following principles: Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis; Assess practice supply and demand, and balance patient load accordingly; Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need. **Metric 1: P-5.1:** Determine Panel size a. Data Source: E-MDs Electronic medical record database Milestone 5 Estimated Incentive Payment: $893,307 **Milestone 6 [I-12]**		**Milestone 8 [I-12]** Based on criteria, improve the number of eligible patients that are assigned to the medical homes. **Metric 1: I-12.1:** Increase the percent of eligible patients assigned to medical homes by 10% over baseline. Data Source: E-MDs Electronic Medical Record database Milestone 8 Estimated Incentive Payment: $1,413,257 **Milestone 9 [I-13]** New patients assigned to a medical home receive their first appointment in a timely manner **Metric 1: I-13.1:** Improve percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days over baseline by 5%. Data Source: E-MDs Electronic Medical Record database Milestone 9 Estimated Incentive Payment: $1,413,257	**Milestone 10 [I-12]** Based on criteria, improve the number of eligible patients that are assigned to the medical homes. **Metric 1: I-12.1:** Increase the percent of eligible patients assigned to medical homes, where "eligible" by 15% over baseline. Data Source: E-MDs Electronic Medical Record database Milestone 10 Estimated Incentive Payment: $1,141,139 **Milestone 11 [I-13]** New patients assigned to a medical home receive their first appointment in a timely manner **Metric 1: I-13.1:** Improve percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days over baseline by 7%. Data Source: E-MDs Electronic Medical Record database Milestone 11 Estimated Incentive Payment: $1,141,139

020908201.2.3	*2.1.2*	*2.1.2 (A-F)*	*ENHANCE MEDICAL HOMES - HEALING HANDS MINISTRIES*	
Texas Health Presbyterian Hospital Dallas				*020908201*
Related Category 3 Outcome Measure(s)	**020908201.3.8**	*3.IT-11.5* *3.IT-5.1*	*Addressing Health Disparities in Minority Populations: All-Cause Admission Rate for Chronically-Ill patients- as defined by performing provider Cost of Care*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
community and family need. **Metric 1: P-5.1:** Determine Panel size71 a. Data Source: E-MDs Electronic medical record database Milestone 2 Estimated Incentive Payment: $691,974 **Milestone 3 [I-12]** Based on criteria, improve the number of eligible patients that are assigned to the medical homes. **Metric 1: I-12.1:** Establish baseline for the number of eligible patients assigned to medical homes, where "eligible" is defined by the performing provider. Data Source: E-MDs Electronic Medical Record database Milestone 3 Estimated Incentive Payment: $691,975 **Milestone 4 [I-13]** New patients assigned to a medical home receive their first appointment in a timely manner **Metric 1: I-13.1:** Establish percent of	Based on criteria, improve the number of eligible patients that are assigned to the medical homes. **Metric 1: I-12.1:** Increase the percent of eligible patients assigned to medical homes by 5%. over baseline. Data Source: E-MDs Electronic Medical Record database Milestone 1 Estimated Incentive Payment: $893,307 **Milestone 7 [I-13]** New patients assigned to a medical home receive their first appointment in a timely manner **Metric 1: I-13.1:** Improve the number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days by 3% over baseline. Data Source: E-MDs Electronic Medical Record database Milestone 7 Estimated Incentive Payment: $893,307		

020908201.2.3	*2.1.2*	*2.1.2 (A-F)*	*ENHANCE MEDICAL HOMES - HEALING HANDS MINISTRIES*	
Texas Health Presbyterian Hospital Dallas				*020908201*
Related Category 3 Outcome Measure(s)	**020908201.3.8**	*3.IT-11.5* *3.IT-5.1*	*Addressing Health Disparities in Minority Populations: All-Cause Admission Rate for Chronically-Ill patients- as defined by performing provider Cost of Care*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days Data Source: E-MDs Electronic Medical Record database Milestone 4 Estimated Incentive Payment: $691,975				
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): **$2,767,898***		Year 3 Estimated Milestone Bundle Amount: **$2,679,921***	Year 4 Estimated Milestone Bundle Amount: **$2,826,514***	Year 5 Estimated Milestone Bundle Amount: **$2,282,278***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $10,556,611				

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Project Option 2.9.1 - Establish/Expand a Patient Care Navigation Program

Unique Project ID: 020967801.2.1
Performing Provider Name/TPI: Texas Health Presbyterian Hospital Denton/020967801

Provider: Texas Health Presbyterian Hospital Denton is a 255 bed acute care hospital located in Denton, Texas. Our hospital serves the city of Denton and surrounding communities within a 1,173.3 square mile area and a population of approximately 270,898 people.

Intervention(s): This project will establish a patient care navigation program to identify patients who are at a high risk of disconnect from institutionalized health care and provide services to reduce episodic care. Services that may be provided include but not limited to primary care physician referrals or chronic disease management clinics/services, referrals to resources supporting a variety of socioeconomic needs, patient/family education, follow-up on compliance with referrals and health management plans, reassessment of needs, and others.

Need for the project: The volume of patients seen in the emergency department increased by 8.08% from 2010 to 2011 and an estimated increase of 12.8% expected in 2012. 49.61% of those patients currently utilizing our ED are either unfunded or Medicaid funded patients. A sub-set of these patients utilize the ED inappropriately for management of chronic disease states and/or with increased frequency for episodic care. A patient navigator, protocols, and increased access to primary care for patients should support care management in the right setting and improve overall management of health in this identified population.

Target population: The target population is patients, primarily those without funding or are underfunded, who inappropriately visit the Emergency Department for episodic care, are frequent users of the ED, and/or are those with chronic conditions where assistance with coordination of care could avoid the need for ED visits or hospitalizations. By DY3, at least 100 unique patients are targeted for enrollment in navigation services. Over the course of the waiver period, we anticipate being able to intervene with patients identified frequently utilizing the ED for non-emergent or chronic care evidenced by greater than three (3) visits per year or are identified at risk for fragmented care to reduce avoidable ED visits. (DY4: 550 avoided ED visits in identified population; DY5: 1160 avoided ED visits in identified population).

Category 1 expected patient benefits: This project seeks to reduce ED utilization and provide services to patients who may be unaware of resources available to them. ED RN navigator will navigate patients to primary care and other resources supporting improved care management and improved health. Milestones selected initially include identification of specific patients targeted for navigation and the development of the ED RN navigation program to include hiring, training and providing ongoing education for the ED RN navigators. Other milestones include development of processes supporting enrollment, scheduling, resource referrals, patient tracking, reporting on patients enrolled and other key interventions. Tracking outcomes

of the program including primary care physician referrals for patients without a medical home and a reduction in avoidable patient use of the ED would be monitored.

Category 3 outcomes: IT-9.2 our goal is to reduce ED utilization by 18% in identified population by the end of the waiver period (DY4: 550 avoided ED visits; DY5 1160 avoided ED visits).

Project Description

This project will implement an ED-based nurse navigator program to identify patients who are at high risk of disconnect from institutionalized health care including but not limited to the uninsured or underinsured, frequent users of the ED and/or at high risk for use of the ED for episodic care, and those with chronic conditions where assistance with coordination of care could avoid the need for ED visits or hospitalizations and assist them in more effective and appropriate utilization of health care resources. The ED-based nurse navigator will work with patients and a multidisciplinary healthcare team to:

- Navigate patients to obtain necessary community resources to meet identified patient needs
- Connect patients to primary and preventive care by assisting patients to obtain a PCP and/or enrollment in a chronic disease management clinic to more effectively manage their disease on an ongoing basis
- Intervene as necessary to provide education, assist in coordination of care and monitor identified patients post discharge to encourage compliance with follow-up plan for receiving ongoing care/support for their healthcare needs.
- Facilitate arrangements for care, as appropriate, at a lower level, such as a medical home, outpatient clinic or skilled facility to avoid hospital admission and reduce risk of ongoing utilization of ED for non-emergent care needs.
- Conduct quality improvement for project using methods such as PDSA, rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned", opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Goals and Relationship to Regional Goals

The goals for the program include enrollment of 100 unique patients in the patient navigation program and reduction of their ED utilization, participation in two semi-annual face-to-face meetings or seminars organized by the RHP and increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services by 20% by DY4 and 25% by DY5.

Challenges

While ED costs are expected to outpace reimbursement by $6.8 billion by 2019 (Bamezai, Melnick, Nawathe, 2005) the heaviest financial burden will be those with chronic conditions that account for an estimated $0.85 of every dollar spent on healthcare. The case manager must also address the issues of lack of education, chronic disease and poor primary care access for low-income and uninsured residents in Region 9.

5-Year Expected Outcome for Provider and Patients

The five year goal of the project is to demonstrate improved appropriate utilization of the ED and a reduction in ED visits for the following conditions:

- Congestive Heart Failure
- Diabetes
- End Stage Renal Disease
- Cardiovascular Disease/Hypertension
- Behavioral Health/Substance Abuse
- Chronic Obstructive Pulmonary Disease
- Asthma

Starting Point/Baseline

Utilization of the Texas Health Presbyterian Hospital Denton's Emergency Department has been steadily increasing over the last several years with an 8.08% increase in ED patient volume between 2010 (35050 visits) and 2011 (37833 visits). Estimates for 2012 (42734 visits) indicate an additional 12.8% increase in volume will be noted from 2011 to 2012. 49.61% of the patients currently utilizing our ED are unfunded or Medicaid funded patients increasing from 46.89% in 2010, many of whom routinely use the ED for management of their chronic condition or episodic care. Baseline data regarding an active relationship with a PCP for this population is not known at this time. Opportunities are evident that assistance is needed for patients at risk for receiving fragmented care. Frequent users of the ED for episodic care are comprised of a variety of diagnoses aligned with those identified throughout Denton County discussed earlier. DY 2 will identify at risk patients in our setting and determine types of services and resources needed in this population.

Rationale

The utilization of the Texas Health Presbyterian Hospital Denton's emergency department has been steadily increasing over the last several years as demonstrated by a growth in patient visits from 2010 through 2012 estimated at 21.9% with an increasingly growing unfunded and Medicaid population (up 5.5%). A 24.2% overall growth in Denton County population is expected by 2015 with the Hispanic population comprising 24.9% and all other non-Anglo constituents comprising another 10.8%. It is anticipated that this program provides patients utilizing the ED for non-emergent care or repetitive chronic care needs with a culturally competent ED-based nurse navigator to help connect them to appropriate resources and consistent clinical care. Utilization of the emergency department for management of chronic disease or for episodic care results in higher health care costs and less effective management of

chronic health conditions or disease prevention. Through the implementation of this program, the ED nurse navigator can connect the patients without an established PCP to a healthcare provider, assist in coordination of service amongst specialties, connect the patient to appropriate community resources (financial, transportation, child care, medication support, translation/interpretation services, etc.), provide necessary education for improved self-management skills and assist patients in complying with follow-up care to improve their health and prevent utilization of more costly resources (such as the emergency department or hospital)[383]. Additionally, this specific role can learn from others or share lessons learned with others in the learning collaborative related to this state-wide initiative to improve related outcomes.

Project Components

2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others)

Required core project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
c) Connect patients to primary and preventive care.
d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
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.

Unique community need identification numbers the project addresses

- CN.1: Demographics
- CN.8: Chronic Disease
- CN.10: Patient Safety and Quality
- CN.11: ED Usage and Readmissions

[383] Romania, M. The Benefits of an Emergency Department Case Management Program, *The Pennsylvania Nurse*. September 2006 15:33.

Related Category 3 Outcome Measures

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

Reduce Emergency Visits for target conditions:

- Congestive Heart Failure
- Diabetes
- End Stage Renal Disease
- Cardiovascular Disease/Hypertension
- Behavioral Health/Substance Abuse
- Chronic Obstructive Pulmonary Disease
- Asthma

Implementation of this project should assist in getting the patient the care they require in the right setting for that care, avoiding unnecessary emergency department visits and reduce admissions through improved outpatient management of chronic conditions Studies have demonstrated the effectiveness of establishment with a PCP and case management/navigation program to improve management of patient health and reduce risk of avoidable readmissions.[384]Nurse Navigators assist patients in obtaining resources necessary to more effectively manage their chronic condition or maintain their health to achieve these goals. Providing key information, support and follow-up for self-management strategies actively engages the patient in driving his/her health outcomes.

Relationship to Other Projects

This project is related to 020967801.2.2.1 Expand Chronic Care Management Models. The ED RN navigator/case manager will utilize the chronic care models as a resource to refer patients needing assistance with management of their chronic conditions.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives

Texas Health Kaufman proposed related projects and would be invited to participate in a learning collaborative. Members of the team involved in leading the project would participate in the RHP-wide learning collaborative at least twice a year. Through participation in the collaborative, it is hoped that we would learn how to make our program more effective and to develop partnerships within the collaborative to improve efficiencies and patient outcomes.

In addition, several other performing providers in RHP9 have related projects for expanding or establishing patient care navigation programs (2.9.1):

[384]Emergency Department Case Management *The Dyad Team of Nurse Case Manager and Social Worker Improve Discharge Planning and Patient and Staff Satisfaction While Decreasing Inappropriate Admissions and Costs:A Literature Review* **Darlene P. Bristow, MSN, RN, CCRN; Charlotte A. Herrick, PhD, RN** Lippincott's Case Management Vol. 7, No. 3, 121-128
Romania, M. The Benefits of an Emergency Department Case Management Program, *The Pennsylvania Nurse*. September 2006 15,33.
Cannon, J. and Feldman, J. Washington State Hospital Association. *Potentially Avoidable Emergency Room Use*. February 2011.

Performing Provider	Project Numbers
Baylor Medical Center at Garland	121790303.2.4
Baylor Medical Center at Irving	121776204.2.4
Baylor University Medical Center	139485012.2.3
Children's Medical Center	138910807.2.3
Medical Center of Lewisville (HCA)	094192402.2.3
Methodist Charlton Medical Center	126679303.2.2
Methodist Dallas Medical Center	135032405.2.3
Methodist Richardson Medical Center	209345201.2.2
Parkland Health & Hospital System	127295703.2.7
University of Texas Southwestern	126686802.2.4

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable use to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology: For every ED visit avoided, $421 in cost is saved by the healthcare system.[385] The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

Rationale/Justification: ED visit outcome improvement targets are dependent on the target population served (e.g. the number of frequent flyers, patients with greater than three visits in a year), size (e.g. if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent navigate frequent flyers away from the ED.

Community benefits were calculated using the following factors: lost productivity (net of lost wages), lost in payroll taxes, and lost sales tax. Individual benefits were calculated using the following factors: lost wages, caretaker expense and extension of life (if applicable).

[385] Based on 2011 historical ED visits data for Texas Health Presbyterian Denton

Unique Identifier: *020967801.2.1*	***RH PPP Reference Number:*** *2.9.1*	***Project Components:*** *2.9.1 (a-e)*	***Title:*** *Establish/Expand a Patient Care Navigation program*
Texas Health Presbyterian Hospital Denton			*020967801*
Related Category 3 Outcome Measures:	*020967801.3.1*	*IT-9.2*	*ED appropriate utilization (Stand-alone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. Metric 1 [P-1.1]: Provide report identifying the following: a. Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy). b. Gaps in services and service needs c. How program will identify, triage and manage target population (i.e. policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts). d. Ideal number of patients targeted for enrollment in the patient navigation program. e. Number of Patient Navigators needed to be hired f. Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients.	**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 (& hire the ED-based nurse navigators to act as) navigators, develop procedures (including data collection mechanism) and establish continuing navigator education Metric 1 [P-2.2]: Number of unique patients enrolled in the patient navigation program **Baseline:** 50 **Goal:** 100 unique patients Metric 2 [P-2.3]: Frequency of contact with care navigators for high risk patients. **Data Source**: Patient navigation program materials and database, EHR **Baseline:** 100 encounters **Goal**: 300 encounters	**Milestone 7** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.4]: Percent of at risk patients without a primary care provider (PCP)who are given a scheduled primary care provider appointment **Data source**: Administrative data on patient encounters and scheduling records from patient navigator program **Goal**: 20% of identified patients Milestone 7 Estimated Incentive Payment: $374,361 **Milestone 8** [I-7]: Measure ED visits and/or avoidable hospitalizations for patients enrolled in the navigator program. Metric 1 [I-7]: Number of ED visits and or avoidable hospitalizations in enrolled patients. **Data source**: EHR, administrative	**Milestone 9** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 I-6.4: Percent of at risk patients without a primary care provider (PCP) who are given a scheduled primary care provider appointment **Data source**: Administrative data on patient encounters and scheduling records from patient navigator program **Goal:** 25% of identified patients Milestone 9 Estimated Incentive Payment: : $604,558

Unique Identifier: *020967801.2.1*	***RH PPP Reference Number:*** *2.9.1*	***Project Components:*** *2.9.1 (a-e)*	***Title:*** *Establish/Expand a Patient Care Navigation program*
Texas Health Presbyterian Hospital Denton			*020967801*
Related Category 3 Outcome Measures:	*020967801.3.1*	*IT-9.2*	*ED appropriate utilization (Stand-alone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: EHR, administrative data, state and federal reports **Baseline:** none **Goal:** Use report to develop implementation plan. Milestone 1 Estimated Incentive Payment: $366,597 **Milestone 2** [P-2]: Establish a healthcare navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to hire & train the navigators, develop procedures (including patient identification and enrollment, database development and data collection) and establish continuing navigator education. Metric 1 [P-2.1]: Number of people hired and trained as ED-based nurse navigators **Baseline:** none **Goal:** Two ED nurse navigators hired and	Milestone 3 Estimated Incentive Payment *(maximum amount):* $177,472 **Milestone 4** [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. Especially for disenfranchised or medically complex patients, navigation is about guiding people through and across the healthcare system, from provider to provider, nursing they can get to and make multiple appointments, get prescriptions filled, access to community services for people with special needs (such as getting cancer patients access to support groups), etc. the patient navigator represents the liaison between primary, secondary, tertiary and quaternary health care. Metric 1 [P-5.1]: Collect and report on all the types of patient navigator	data **Goal:** 100% ED visits and avoidable hospitalizations identified for enrolled patients Milestone 8 Estimated Incentive Payment: $374,361	

Unique Identifier: *020967801.2.1*	***RH PPP Reference Number:*** *2.9.1*	***Project Components:*** *2.9.1 (a-e)*	***Title:*** *Establish/Expand a Patient Care Navigation program*
Texas Health Presbyterian Hospital Denton			*020967801*
Related Category 3 Outcome Measures:	*020967801.3.1*	*IT-9.2*	*ED appropriate utilization (Stand-alone 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)**
trained in culturally competent care allowing coverage for 8 hours, seven days a week. **Data Source:** Human Resources employee database; employee training records Metric 2 [P-2.1.1]: Baseline navigation procedures and processes defined for: patient selection/enrollment, patient tracking, appointment scheduling, follow-up face-to-face or by telephone **Baseline:** no current processes or procedures defined **Goal**: Complete 3rd Qtr 2013 **Data Source:** Procedure/process documents Metric 3 [P-2.1.2]: Patient navigation database developed **Baseline:** database not in existence **Goal: Goal 2nd Qtr. 2013** **Data Source:** ED Navigator patient	services provided. **Baseline/Goal:** Data collection completed with at least four reports produced **Data Source:** Navigation reports, team minutes Milestone 4 Estimated Incentive Payment: $177,472 **Milestone 5** [P-8]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers 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-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.		

Unique Identifier: *020967801.2.1*	***RH PPP Reference Number:*** *2.9.1*	***Project Components:*** *2.9.1 (a-e)*	***Title:*** *Establish/Expand a Patient Care Navigation program*
Texas Health Presbyterian Hospital Denton			*020967801*
Related Category 3 Outcome Measures:	*020967801.3.1*	*IT-9.2*	*ED appropriate utilization (Stand-alone 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)**
database, EHR, claims records **Metric 2 [P-2.2]**: Number of unique patients enrolled in the patient navigation program. **Baseline/Goal**: 0/50 unique patients **Data Source:** Patient navigation program database Metric 3 [P-2.3]: Frequency of contact with care navigators for high risk patients. **Baseline/Goal**: 0/150 encounters **Data Source**: Patient navigation program materials and database, HER Milestone 2 Estimated Incentive Payment: $366,598	**Data Source**: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. **Goal:** Attend 2 programs/year Milestone 5 Estimated Incentive Payment: $177,473 **Milestone 6** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.2]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment **Data source**: Administrative data on patient encounters and scheduling records from patient navigator program **Baseline**: Develop **Goal**: 15% of identified patients		

Unique Identifier: *020967801.2.1*	***RH PPP Reference Number:*** *2.9.1*	***Project Components:*** *2.9.1 (a-e)*	***Title:*** *Establish/Expand a Patient Care Navigation program*
Texas Health Presbyterian Hospital Denton			*020967801*
Related Category 3 Outcome Measures:	*020967801.3.1*	*IT-9.2*	*ED appropriate utilization (Stand-alone 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 8 Estimated Incentive Payment: $177,473		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $733,195*****	Year 3 Estimated Milestone Bundle Amount: $709,890*****	Year 4 Estimated Milestone Bundle Amount: $748,722*****	Year 5 Estimated Milestone Bundle Amount: $604,558*****
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $2,796,366			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**
Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Project Option 2.2.1 – Expand Chronic Care Management Models – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases

Unique Project ID: 020967801.2.2
Performing Provider Name/TPI: Texas Health Presbyterian Hospital Denton/020967801

Provider: Texas Health Presbyterian Hospital Denton serves a 1,173.3 square mile area and a population of approximately 270,898 people.

Intervention(s): This project will provide the under serviced who suffer from chronic diabetes and provide them with education and management tools to help them understand their daily regimen and need for monitoring their disease process. In turn, this will reduce the number of 30-day readmissions.

Need for the project: A model to coordinate and prescribe care. A Certified Diabetes Educator, pharmacist, physicians, care navigator, nurses, nutritionist, and a case manager to help coach and patients using the Wagner Chronic Care Model.

Target population: The target population is chronic diabetes patients in need of education and disease management services with A1C>9, history of DKA, > one admission in the last 12 months as criteria. More specifically, DY 2 will begin hiring staff (certified diabetes educator) and providing training on the Wagner Chronic Care Model; DY3 will include formalizing multi-disciplinary teams, pursuant to the Chronic Care Model and identify as well as screen/test 260 patients; DY 4 will include a 10 percent increase of the patients identified/screened to a total of 286; and DY 5 will include a five (5) percent increase of patients identified/screened to a grand total of 300 patients. Again, THDN will focus on the Wagner Chronic Care Model to educate them and help those patients establish self-management goals.

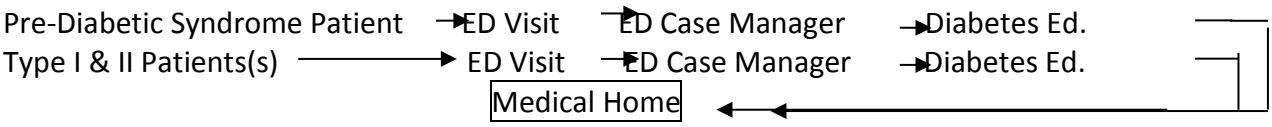
Category 1 expected patient benefits: This project seeks to assist the under served who are need of education, self management tools for managing chronically ill diabetes patients and reduce the number of 30-day readmissions.

Category 3 outcomes: IT-1.10 our goal is to decrease the number of diabetic clinic patients whose HbA1C is >9.0% by 15% to a total of 300 patients by DY5.

Project Description
There is not a consistent method for identifying diabetes patients at THDN, which has resulted in a variability of care for the underserved. Some of these patients have not been effectively educated on how to manage their diabetes and/or understand their daily regimen and the need for monitoring their disease process. The gap has created a lack of understanding for their long-term goals, which impact their quality of life.

Our proposed intervention will help individuals who are traditionally underserved and give them access to the diabetes care they need. This proposed program is designed to provide chronic diabetes patients with education and management to help them understand their daily regimen and need for monitoring their disease process. It will also create care models and coordinate prescribed care. The program staff will consist of non-physician health professionals such as a certified diabetes educator, registered dietitians, pharmacists, nurses, care navigator, case management/social workers. Physicians will be a key part of the team to provide clinical care and medication adjustments and prescriptions. Patients will be identified by: first, partnering with primary care clinicians to utilize protocols: A1C>9, history of DKA, > one admission in the last 12 months as criteria for referrals to outpatient diabetes education. Second, the ED case management and inpatient diabetes educator will identify patients with the same criteria as above, help identify a patient centered medical home for diabetics that have not received diabetes education ever or within the last five years, and provide education for others as needed and within the community. This program will not only help provide better care to the underserved through medical management skills, but it will also reduce the number of number 30-day Readmission Rate.

ED Algorithm



Goals and Relationship to Regional Goals:

The goal is to have a multi-disciplinary care team tailored to provide continuing medical care and ongoing patient self-management education. This concept will support the prevention of acute complications and reduce the risk of long-term (complications) associated with diabetes.

Diabetes care is complex. There are many issues beyond glycemic control that need to be addressed when supporting a diabetic care regimen. Standards of care are needed for patients diagnosed with diabetes. In turn, diabetics will use multidisciplinary protocols developed by our team of experts. Patients will receive diabetes care, general treatment goals, and tools to evaluate their disease process.

Our proposed intervention will help individuals who are traditionally under served and give them access to diabetes education and self management skills, so they can better manage their diabetes. Our proposed delivery system includes the use of navigation services; hiring staff; and training staff in DY 2. The lead clinician will be a Certified Diabetes Educator that will work pharmacists, physicians, nurses, patient navigator, physicians, nutritionists and a case manager/social work to help assist with education, management services and navigate to a medical home. The physicians will be a key part of the team to provide clinical care, medication adjustments and prescriptions.

A major goal throughout the North Texas region is provide education on access, prevention and management to the underserved who suffer from diabetes. This project would contribute toward achieving that goal by improving the level of education for chronic care diabetes patients in Denton County who are underserved that are in need of diabetes education, training, and clinical interventions. This program will not only help provide better care to the underserved through medical management skills, but it will also reduce the number of number 30-day Readmission Rate.

Challenges

Denton County is one of the fastest-growing counties in the U.S. As of the 2010 census, its population was 662,614, which is a 41.4% increase in population between the years 2000-2007. The demographics of the county was 75% White, 8.4% Black or African American, 0.7% Native American, 6.6% Asian, 0.1% Pacific Islander, and 2.9% from two or more races. 18.2% of the population was of Hispanic or Latino origin.

According to the US Department of Health and Human Services 2007 Report the Denton County population consists of 4.6% diabetics, 23.3% obese, 17.3% high blood pressure, 16.2% use tobacco, 22.2% do not exercise and 80.1% consume few fruits and vegetables. The THDN ED has experienced significant growth over the last three years.

YTD as of 9/2012 ER Visits = 32,132		
Medicaid & Mg'ed Medicaid	6,935	21.6%
Self Pay	9,173	28.6%
2011 – ER Visits = 37,883		
Medicaid & Mg'ed Medicaid	8,412	22.2%
Self Pay	9,625	25.4%
2010 – ER Visits – 35,050		
Medicaid & Mg'ed Medicaid	7,465	21.3%
Self Pay	8,970	25.6%

5-Year Expected Outcome for Provider and Patients

We anticipate a decrease in ED usage as a clinic; a decrease of readmissions for chronic diabetes patients; and it will enable us to identify new diabetics and track their progress. First, the outcome is to reduce readmissions through the ED for diabetic patients by 15% from our baseline. Second, the outcome is to track and provide medical assistance for 300 diabetic patients.

Starting Point/Baseline

The starting point includes hiring a Certified Diabetes Educator to develop a delivery model to reach those in need of diabetes support. The Educator will identify medical homes by engaging stakeholders from local agencies, physician offices and nutritionists. As a whole they work collectively to develop and use care models and protocol for helping uninsured patients manage their diabetes. In conjunction, the Educator will identify needed resources; determine timelines; develop implementation plans and establish baseline rates. During the first phase the Educator will work with IT to develop and test data systems for tracking the patients over time as a method of monitoring their progress.

At the conclusion of the waiver period the expectation is to decrease ED usage and reduce readmissions of chronic diabetes patients by 10 percent.

Rationale

Currently our ED provides an exemplary level of care to a diverse medical population. In order to prevent diabetes complications, patients need an alternative toward using the ED for primary care. We have selected this project to reduce complications associated with diabetes, reduce ED visits and readmissions, improve quality of life for this diverse populous, and eventually help them experience a better quality of life. This project addresses the gaps in care for the diabetic population and improves their knowledge of the disease process. Our milestones and metrics will guide us during the development of our diabetes program. In doing so, our team will use the Wagner Chronic Care Model to guide diabetes management plans. Our process includes: (1) Establishing a multidisciplinary team including Physicians, Nurse Practitioners, Care Navigator, Diabetes Educators, Registered Dietitians, Clinical Social Workers, Registered Nurses, Pharmacists, and support staff. (2) Develop relationships with local agencies and physician offices to collectively develop and use care models for helping uninsured patients manage their diabetes. (3) Develop policies, procedures, and data collection tools to effectively run the coordinated program and monitor effectiveness, reducing fragmented care.

Project Components

The following core project components are included in this project: A) Design and implement a protocol that includes a multi-disciplinary team to help patients navigate the health care system. B) Ensure patients can access care teams by person, email or phone. C) Increase patient engagement through education, group visits, self-management support, improved patient-provider communication techniques, and coordination of community resources. D) Implement projects to empower patients to stay healthy and self-manage their diabetes. E) Conduct quality improvement for the project using methods such as rapid cycle improvement.

Unique community need identification numbers the project addresses

This project relates to project 020967801.2.9.1 Establish/Expand Patient Care Navigation Program. The patient navigation program assists with the identification of at risk patient who

might benefit from closer monitoring. The navigator would refer the patient to the Diabetes Program for management of their disease.

- CN.1: Demographics Texas Health Presbyterian Hospital Denton/020967801.2.2
- CN.8: Chronic Disease Texas Health Presbyterian Hospital Denton/020967801.2.2
  Texas Health Presbyterian Hospital Denton/020967801.3.2
- CN.11: Emergency Department Usage and Readmissions Texas Health Presbyterian Denton/020967801.3.3

How the project represents a new initiative

This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures and Rationale

Stand Alone Measure: 1.10 Diabetes care: HbA1c poor control (>9.0%)

a. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or 2) who had hemoglobin Ac (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 2)

Relationship to other Projects

This project relates to project 020967801.2.9.1 Establish/Expand Patient Care Navigation Program. The patient navigation program assists with the identification of at risk patient who might benefit from closer monitoring. The navigator would refer the patient to the Diabetes Program for management of their disease.

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

The safety net performing providers within RHP 9 have related projects to expand their chronic care management models and incorporate interventions for specific chronic disease or implement a disease registry. The following projects were identified:

Performing Provider	Unique Project ID	Project Option
Baylor University Medical Center	139485012.2.2	Expand Chronic Care Management Model
Baylor Medical Center at Garland	121790303.2.2	Expand Chronic Care Management Model
Baylor Medical Center at Irving	121776204.2.2	Expand Chronic Care Management Model
Trinity Medical Center (Baylor-Carrollton)	195018001.2.1	Expand Chronic Care Management Model
Children's Medical Center	138910807.1.3	Implement pediatric disease registry
Denton County HHS	13660803.2.1	Implement disease registry – diabetes
Methodist Charlton Medical Center	126679303.2.1	Expand Chronic Care Management Model
Methodist Dallas Medical Center	135032405.2.1	Expand Chronic Care Management Model
Methodist Richardson Medical Center	209345201.2.1	Expand Chronic Care Model
UTSW – Faculty Practice Plan	126686802.2.2	Expand Chronic Care Management Model

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable use to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology: For every inpatient readmission avoided, $8297 in cost is saved by the healthcare system. Healthcare costs are calculated by multiplying $8297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

For every inpatient admission avoided, $8297 in cost is saved by the healthcare system.[386] Healthcare costs are calculated by multiplying $8297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

Rationale/Justification: Inpatient readmissions outcome improvement targets are dependent on the target population served (e.g. aging populations will have increased admissions due to higher incidence rates), size (e.g. if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable readmissions (e.g. keeping lower acuity patients under observation instead of admitting them).

Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g. if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g. keeping lower acuity patients under observation instead of admitting them).

Community benefits were calculated using the following factors: lost productivity (net of lost wages), work absenteeism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using the following factors: lost wages, caretaker expense and extension of life (if applicable).

[386] Based on 2011 historical inpatient diabetes admissions data for Texas Health Arlington Memorial

UNIQUE IDENTIFIER: *020967801.2.2*	***RH PPP REFERENCE NUMBER:*** *2.2.1*	***PROJECT COMPONENTS:*** *2.2.1 (A-E)*	***TITLE:*** *REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES*	
Performing Provider: Texas Health Presbyterian Hospital Denton				*020967801*
Related Category 3 Outcome Measure(s):	*020967801.3.2* *020967801.3.3*	*IT-1.10* ~~*IT-3.3*~~	*Diabetes care: HbA1c poor control (>9.0%)* ~~*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-3]: Develop a comprehensive care management program Metric 1 [P-3.1]: Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and Institute of Chronic Illness Care's Assessment Model may be utilized in program development. Data Source: Creating planning documentation Goal: 2Q 2013 Metric 2 [P-3.2]:Increase the number of patients enrolled in a care management program over baseline Goal: 260 number of patients Data source: Program enrollment records Milestone 1 Estimated Incentive Payment: $68,347 **Milestone 2** [P-2]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality	**Milestone 3** [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]: Increase the number of multi-disciplinary teams (e.g., teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams Data Source: Number of stakeholders educated Goal: 4Q 2013 Milestone 3 Estimated Incentive Payment: $66,175 **Milestone 4** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention. Metric 1 [P-9.1]: Increase the number of patients identified as needing screening test, preventative test, or other clinical services Goal: 260 number of patients receiving	**Milestone 5** [I-17]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 1 [I-17.1]: 10 percent over baseline additional patients receive care under the Chronic Care Model for a chronic disease or MCC a) Diabetes Goal: 286 patients Data Source: Enrollment record Milestone 5 Estimated Incentive Payment: $139,590	**Milestone 6** [I-17]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 1 [I-17.1]: five percent additional patients receive care under the Chronic Care Model for a chronic disease or MCC a) Diabetes Goal: 300 patients Data Source: Patients enrolled Milestone 6 Estimated Incentive Payment: $112,712

UNIQUE IDENTIFIER: *020967801.2.2*	***RH PPP REFERENCE NUMBER:*** *2.2.1*	***PROJECT COMPONENTS:*** *2.2.1 (A-E)*	***TITLE:*** *REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES*	
Performing Provider: Texas Health Presbyterian Hospital Denton				*020967801*
Related Category 3 Outcome Measure(s):	*020967801.3.2* *020967801.3.3*	*IT-1.10* ~~*IT-3.3*~~	*Diabetes care: HbA1c poor control (>9.0%)* ~~*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)**
clinic and chronic disease care. <u>Metric 1</u> [P-2.1]:Increase percent of staff trained Goal: 100 percent of staff hired and trained Data source: HR, training program materials Milestone 2 Estimated Incentive Payment: $68,348	screenings Data source: clinic documentation Milestone 4 Estimated Incentive Payment: $66,175		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $136,695*	Year 3 Estimated Milestone Bundle Amount: $132,350*	Year 4 Estimated Milestone Bundle Amount: $139,590****	Year 5 Estimated Milestone Bundle Amount: $112,712*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $521,347			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program

Unique Project ID: 09410302.2.1
Performing Provider Name/TPI: Texas Health Presbyterian Hospital Kaufman/09410302

Provider: Texas Health Presbyterian Hospital Kaufman serves an 800.9 square mile area and a population of approximately 107,250 people.

Intervention(s): This project will establish a patient care navigation program to identify patients who are at a high risk of disconnect from institutionalized health care and provide services to reduce episodic care.

Need for the project: A patient navigator, protocols, and increased access to primary care for patients.

Target population: The target population is patients that visit the Emergency Department for episodic care, frequent users of the ED, and those with chronic conditions where assistance with coordination of care could avoid the need for ED visits or hospitalizations.

Category 1 expected patient benefits: This project seeks to reduce ED utilization as a primary care resource and provide more appropriate services to patients who may be unaware of resources available to them. Over the course of the waiver, we anticipate being able to intervene with a minimum of 1000 patients (DY2: 100 patients; DY3: 150 patients; DY3: 200 patients; DY4: 250 patients; DY5: 300 patients)

Category 3 outcomes: IT-9.2 our goal is to reduce ED utilization of the target populations by 18%.

Project Description
This project will implement an ED-based nurse navigator program to identify patients who are at high risk of disconnect from institutionalized health care including but not limited to the uninsured or underinsured, frequent users of the ED and/or at high risk for use of the ED for episodic care, and those with chronic conditions where assistance with coordination of care could avoid the need for ED visits or hospitalizations and assist them in more effective and appropriate utilization of health care resources. The ED-based nurse navigator will work with patients and a multidisciplinary healthcare team to:

- Navigate patients to obtain necessary community resources to meet identified patient needs
- Connect patients to primary and preventive care by assisting patients to obtain a PCP and/or enrollment in a chronic disease management clinic to more effectively manage their disease on an ongoing basis

- Intervene as necessary to provide education, assist in coordination of care and monitor identified patients post discharge to encourage compliance with follow-up plan for receiving ongoing care/support for their healthcare needs.
- Facilitate arrangements for care, as appropriate, at a lower level, such as a medical home, outpatient clinic or skilled facility to avoid hospital admission and reduce risk of ongoing utilization of ED for non-emergent care needs.
- Conduct quality improvement for project using methods such as PDSA, rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned", opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations

Goals and Relationship to Regional Goals

The goals for the program include enrollment of 100 unique patients in the patient navigation program and reduction of their ED utilization, participation in two semi-annual face-to-face meetings or seminars organized by the RHP and increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services by 20%.

Challenges

While ED costs are expected to outpace reimbursement by $6.8 billion by 2019 (Bamezai, Melnick, Nawathe, 2005) the heaviest financial burden will be those with chronic conditions that account for an estimated $0.85 of every dollar spent on healthcare. The case manager must also address the issues of lack of education, chronic disease and poor primary care access for low-income and uninsured residents in Region 9.

5-Year Expected Outcome for Provider and Patients

The five year goal of the project is to demonstrate improved appropriate utilization of the ED and a reduction in ED visits for the following conditions:

- Congestive Heart Failure
- Diabetes
- End Stage Renal Disease
- Cardiovascular Disease/Hypertension
- Behavioral Health/Substance Abuse
- Chronic Obstructive Pulmonary Disease
- Asthma

Starting Point/Baseline

Utilization of the Texas Health Presbyterian Hospital Kaufman's Emergency Department has been steadily increasing over the last several years with an 8.77% increase in ED patient volume between 2010 (21,821 visits) and 2011 (23,918visits). Estimates for 2012 (26,391 visits) indicate

an additional 9.37% increase in volume will be noted from 2011 to 2012. 60.04% of the patients currently utilizing our ED are unfunded or Medicaid funded patients increasing from 59.02% in 2010, many of whom routinely use the ED for management of their chronic condition or episodic care. Baseline data regarding an active relationship with a PCP for this population is not known at this time. Opportunities are evident that assistance is needed for patients at risk for receiving fragmented care. Frequent users of the ED for episodic care are comprised of a variety of diagnoses aligned with those identified throughout Kaufman County. DY 2 we will identify at risk patients in our setting and determine types of services and resources needed in this population

Rationale

It is anticipated that this program patients utilizing the ED for non-emergent care or repetitive chronic care needs with a culturally competent ED-based nurse navigator to help connect them to appropriate resources and consistent clinical care. Utilization of the emergency department for management of chronic disease or for episodic care results in higher health care costs and less effective management of chronic health conditions or disease prevention. Through the implementation of this program, the ED nurse navigator can connect the patients without an established PCP to a healthcare provider, assist in coordination of service amongst specialties, connect the patient to appropriate community resources (financial, transportation, child care, medication support, translation/interpretation services, etc.), provide necessary education for improved self-management skills and assist patients in complying with follow-up care to improve their health and prevent utilization of more costly resources (such as the emergency department or hospital). Additionally, this specific role can learn from others or share lessons learned with others in the learning collaborative related to this state-wide initiative to improve related outcomes

Project components

2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others)

Required core project components:

a) identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
c) Connect patients to primary and preventive care.
d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.

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

Unique community need identification numbers the project addresses

- CN.1: Demographics
- CN.8: Chronic Disease
- CN.10: Patient Safety and Quality
- CN.11: ED Usage and Readmissions

Related Category 3 Outcome Measures

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

Reduce Emergency Visits for target conditions:

- Congestive Heart Failure
- Diabetes
- End Stage Renal Disease
- Cardiovascular Disease/Hypertension
- Behavioral Health/Substance Abuse
- Chronic Obstructive Pulmonary Disease
- Asthma

Implementation of this project should assist in getting the patient the care they require in the right setting for that care, avoiding unnecessary emergency department visits and reduce admissions through improved outpatient management of chronic conditions Studies have demonstrated the effectiveness of establishment with a PCP and case management/navigation program to improve management of patient health and reduce risk of avoidable readmissions.[387]Nurse Navigators assist patients in obtaining resources necessary to more effectively manage their chronic condition or maintain their health to achieve these goals. Providing key information, support and follow-up for self-management strategies actively engages the patient in driving his/her health outcomes.

[387]Emergency Department Case Management *The Dyad Team of Nurse Case Manager and Social Worker Improve Discharge Planning and Patient and Staff Satisfaction While Decreasing Inappropriate Admissions and Costs:A Literature Review* Darlene P. Bristow, MSN, RN, CCRN; Charlotte A. Herrick, PhD, RN Lippincott's Case Management Vol. 7, No. 3, 121-128 Romania, M. The Benefits of an Emergency Department Case Management Program, *The Pennsylvania Nurse*. Sep 2006 15,33. Cannon, J. and Feldman, J. Washington State Hospital Association. *Potentially Avoidable Emergency Room Use*. February 2011.

Relationship to Other Projects

This project is related to 09410302.2.2 Expand Chronic Care Management Models. The ED case manager will utilize the chronic care models as a resource to refer patients needing assistance with management of their chronic conditions.

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

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable use to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

In addition, several of the safety net providers and/or their system providers in RHP9 have related projects for expanding or establishing patient care navigation programs (2.9.1):

Performing Provider	Unique Project
Baylor Medical Center at Garland	121790303.2.4
Baylor Medical Center at Irving	121776204.2.4
Baylor University Medical Center	139485012.2.3
Children's Medical Center	138910807.2.3
Medical Center of Lewisville (HCA)	094192402.2.3
Methodist Charlton Medical Center	126679303.2.2
Methodist Dallas Medical Center	135032405.2.3
Methodist Richardson Medical Center	209345201.2.2
University of Texas Southwestern	126686802.2.4

Project Valuation

For every ED visit avoided, $421 in cost is saved by the healthcare system.[388] The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

Rationale/Justification: ED visit outcome improvement targets are dependent on the target population served (e.g. the number of frequent flyers, patients with greater than three visits in a year), size (e.g. if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent navigate frequent flyers away from the ED.

[388] Based on 2011 historical ED visits data for Texas Health Presbyterian Kaufman

Community benefits were calculated using the following factors: lost productivity (net of lost wages), lost in payroll taxes, and lost sales tax. Individual benefits were calculated using the following factors: lost wages, caretaker expense and extension of life (if applicable).

09410302.2.1	*2.9.1*	*2.9.1 (a-e)*	***Title:*** *Establish/Expand a Patient Care Navigation program*
Texas Health Presbyterian Hospital Kaufman			*09410302*
Related category 3 Outcome Measures:	*09410302.3.1*	*IT-9.2*	*ED Appropriate Utilization*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. Metric 1 [P-1.1]: Provide report identifying the following: a. Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy). b. Gaps in services and service needs c. How program will identify, triage and manage target population (i.e. policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts). d. Ideal number of patients targeted for enrollment in the patient navigation program. e. Number of Patient Navigators needed to be hired f. Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that	**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. Program includes training and hiring ED-based nurse navigators; development of procedures and data collection mechanism and establishment of continuing navigator education. Metric 1 [P-2.2]: Number of unique patients enrolled in the patient navigation program **Baseline:** 50 **Goal:** 100 unique patients Metric 2 [P-2.3]: Frequency of contact with care navigators for high risk patients. **Data Source**: Patient navigation program materials and database, EHR **Baseline:** 100 encounters **Goal**: 300 encounters Milestone 3 Estimated Incentive	**Milestone 7** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.4]: Percent of at risk patients without a primary care provider (PCP)who are given a scheduled primary care provider appointment **Data source**: Administrative data on patient encounters and scheduling records from patient navigator program **Goal**: 20% of identified patients Milestone 7 Estimated Incentive Payment: $300,200 **Milestone 8** [I-7]: Number of patients with PCP referral who “show” for initial appointment. Metric 1 [I-7.1]: Number of patients referred to PCP who “show” for initial appointment a)Numerator: Number of referred	**Milestone 9** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 I-6.4: Percent of at risk patients without a primary care provider (PCP) who are given a scheduled primary care provider appointment **Data source**: Administrative data on patient encounters and scheduling records from patient navigator program **Goal:** 25% of identified patients Milestone 9 Estimated Incentive Payment: $161,598 **Milestone 10** [I-7]: Increase number of patients with PCP referral who “show” for initial appointment. Metric 1 [I-7.1]: Number of patients referred to PCP who “show” for initial appointment a)Numerator: Number of

09410302.2.1	*2.9.1*	*2.9.1 (a-e)*	***Title:*** *Establish/Expand a Patient Care Navigation program*
Texas Health Presbyterian Hospital Kaufman			*09410302*
Related category 3 Outcome Measures:	*09410302.3.1*	*IT-9.2*	*ED Appropriate Utilization*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
required medical treatment, percentage of monolingual patients. **Data Source**: EHR, administrative data, state and federal reports **Baseline:** none **Goal:** Use report to develop implementation plan. Milestone 1 Estimated Incentive Payment: $293,975 **Milestone 2** [P-2]: Establish a healthcare navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to hire & train the navigators, develop procedures (including patient identification and enrollment, database development and data collection) and establish continuing navigator education. Metric 1 [P-2.1]: Number of people hired and trained as ED-	Payment *(maximum amount):* $142,315 **Milestone 4** [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. Especially for disenfranchised or medically complex patients, navigation is about guiding people through and across the healthcare system, from provider to provider, nursing they can get to and make multiple appointments, get prescriptions filled, access to community services for people with special needs (such as getting cancer patients access to support groups), etc. the patient navigator represents the liaison between primary, secondary, tertiary and quaternary health care. Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided. **Baseline/Goal:** Data collection completed with at least four reports	patients to PCP who "show" for initial appointment b)Denominator: Total number of patients referred with initial appointment **Goal:** 50% of patients referred to PCP "show" for initial appointment **Data Source**: Internal database Milestone 8 Estimated Incentive Payment: $300,200	referred patients to PCP who "show" for initial appointment b)Denominator: Total number of patients referred with initial appointment **Goal:** 70% of patients referred to PCP "show" for initial appointment **Data Source**: Internal database Milestone 10 Estimated Incentive Payment: $161,598 **Milestone 11** [I-8]: Reduction in ED use by identified ED frequent users receiving navigation Services Metric 1 [I-8.1]: ED visits pre- and post-navigation services by individuals identified as ED frequent users. **Goal**: 18% reduction from baseline for inappropriate ED visits **Data Source**: Claims and EHR/registry

09410302.2.1	*2.9.1*	*2.9.1 (a-e)*	***Title:*** *Establish/Expand a Patient Care Navigation program*
Texas Health Presbyterian Hospital Kaufman			*09410302*
Related category 3 Outcome Measures:	*09410302.3.1*	*IT-9.2*	*ED Appropriate Utilization*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
based nurse navigators **Baseline:** none **Goal:** Two ED nurse navigators hired and trained in culturally competent care allowing coverage for 8 hours, seven days a week. **Data Source:** Human Resources employee database; employee training records Metric 2 [P-2.1.1]: Baseline navigation procedures and processes defined for: patient selection/enrollment, patient tracking, appointment scheduling, follow-up face-to-face or by telephone **Baseline:** no current processes or procedures defined **Goal**: Complete 3rd Qtr 2013 **Data Source:** Procedure/process documents Metric 3 [P-2.1.2]: Patient navigation database developed	produced **Data Source:** Navigation reports, team minutes Milestone 4 Estimated Incentive Payment: $142,315 **Milestone 5** [P-8]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers 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-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Data Source**: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes.		Milestone 11 Estimated Incentive Payment: $161,599

09410302.2.1	*2.9.1*	*2.9.1 (a-e)*	***Title:*** *Establish/Expand a Patient Care Navigation program*
Texas Health Presbyterian Hospital Kaufman			*09410302*
Related category 3 Outcome Measures:	*09410302.3.1*	*IT-9.2*	*ED Appropriate Utilization*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Baseline: database not in existence **Goal: Goal 2nd Qtr. 2013** **Data Source:** ED Navigator patient database, EHR, claims records **Metric 2 [P-2.2]**: Number of unique patients enrolled in the patient navigation program. **Baseline/Goal**: 0/50 unique patients **Data Source:** Patient navigation program database Metric 3 [P-2.3]: Frequency of contact with care navigators for high risk patients. **Baseline/Goal**: 0/150 encounters **Data Source**: Patient navigation program materials and database, HER Milestone 2 Estimated Incentive Payment: $ 293,974	**Goal:** Attend 2 programs/year Milestone 5 Estimated Incentive Payment: $142,315 **Milestone 6** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.2]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment **Data source**: Administrative data on patient encounters and scheduling records from patient navigator program **Baseline**: Develop **Goal**: 15% of identified patients Milestone 6 Estimated Incentive Payment: $142,316		

09410302.2.1	*2.9.1*	*2.9.1 (a-e)*	***Title:*** *Establish/Expand a Patient Care Navigation program*	
Texas Health Presbyterian Hospital Kaufman				*09410302*
Related category 3 Outcome Measures:	*09410302.3.1*	*IT-9.2*	*ED Appropriate Utilization*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $587,949*	Year 3 Estimated Milestone Bundle Amount: 569,261*	Year 4 Estimated Milestone Bundle Amount: $600,400*	Year 5 Estimated Milestone Bundle Amount: $484,795*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $2,242,406			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Project Option 2.2.1 – Expand Chronic Care Management Models – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases

Unique Project ID: 09410302.2.2
Performing Provider Name/TPI: Texas Health Presbyterian Hospital Kaufman/09410302

Provider: Texas Health Presbyterian Hospital Kaufman serves an 800.9 square mile area and a population of approximately 107,250 people.

Intervention(s): This project will provide chronic diabetes patients education and management to help them understand their daily regimen and need for monitoring their disease process. Need for the project: A model to coordinate and prescribe care. A Certified Diabetes Educator, pharmacist, physicians, nurses, nutritionist, and a case manager will help coach and navigate patients.

Target population: The target population is patients with A1C>9, history of DKA, > one admission in the last 12 months as criteria.

Category 1 expected patient benefits: This project seeks to manage chronically ill patients diagnosed with diabetes.

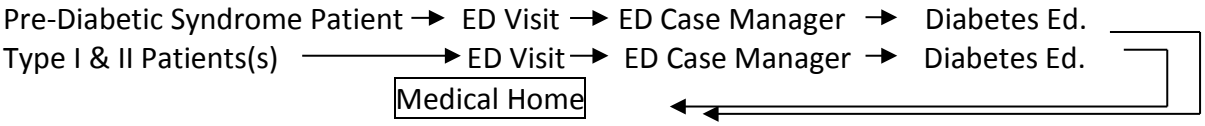
Category 3 outcomes: IT-1.10 our goal is to decrease the number of diabetic clinic patients whose HbA1C is >9.0% by 15%

Project Description

There is not a consistent method for identifying diabetes patients at THK, which has resulted in a variability of care for the underserved. Some of these patients have not been effectively educated on how to manage their diabetes and/or understand their daily regimen and the need for monitoring their disease process. The gap has created a lack of understanding for their long-term goals, which impact their quality of life.

This proposed program is designed to help those in need of education on diabetes management. It will also create care models and coordinate prescribed care. Patients will be identified by: first, partnering with primary care clinicians to utilize protocols: A1C>9, history of DKA, > one admission in the last 12 months as criteria for referrals to outpatient diabetes education. Second, the ED case manager and inpatient diabetes educator will identify patients with the same criteria as above, help identify a patient centered medical home for diabetics that have not received diabetes education ever or within the last five years, and provide education for others as needed and within the community.

ED Algorithm



Goals and Relationship to Regional Goals

The goal is to have a multi-disciplinary care team tailored to provide continuing medical care and ongoing patient self-management education. This concept will support the prevention of acute complications and reduce the risk of long-term (complications) associated with diabetes.

Diabetes care is complex. There are many issues beyond glycemic control that need to be addressed when supporting a diabetic care regimen. Standards of care are needed for patients diagnosed with diabetes. In turn, diabetics will use multidisciplinary protocols developed by our team of experts. Patients will receive diabetes care, general treatment goals, and tools to evaluate their disease process.

Our proposed delivery system includes the use of a Certified Diabetes Educator, pharmacists, physicians, nurses, nutritionists and a case manager to help coach and navigate patients as needed for diabetic care.

A major goal throughout the North Texas region is provide education on access, prevention and management to the underserved who suffer from diabetes. This project would contribute toward achieving that goal by improving the level of education for chronic care diabetes patients in Kaufman County who are underserved that are in need of diabetes education, training, and clinical interventions.

Challenges

31% of people in Texas Health Kaufman's service area are uninsured, underinsured or insured by Medicaid. The number of patients in our ED and hospital with a primary diagnosis of diabetes is a small percentage of our diabetes management program. Rather, diabetes is a comorbidity for a greater number of our patients who have multiple chronic conditions. Therefore there needs to be a link from the ED and inpatient areas to outpatient resources and education to assist this population. A decrease in morbidity of diabetes will decrease the morbidity of other chronic conditions affected by diabetes including but not limited to CAD, PVD, stroke and renal disease.

The ED currently does not utilize a case manager or a diabetes educator to provide screening, care and/or directing diabetic patients toward a medical home. As patients are seen in the ED, there is also a lack of systems that address the secondary diagnosis's consistently. In turn, this inconsistency creates a variability of care. The proposed project addresses those challenges and provides a better standard of care.

5-Year Expected Outcome for Provider and Patients

We anticipate a decrease in ED usage as a clinic; a decrease of readmissions for chronic diabetes patients; and it will enable us to identify new diabetics and track their progress.

Starting Point/Baseline

The starting point includes hiring a Certified Diabetes Educator to develop a delivery model to reach those in need of diabetes support. The Educator will identify medical homes by engaging stakeholders from local agencies, physician offices and nutritionists. As a whole they work collectively to develop and use care models and protocol for helping uninsured patients manage their diabetes. In conjunction, the Educator will identify needed resources; determine timelines; develop implementation plans and establish baseline rates. During the first phase the Educator will work with IT to develop and test data systems for tracking the patients over time as a method of monitoring their progress.

At the conclusion of the waiver period the expectation is to decrease ED usage and reduce readmissions of chronic diabetes patients by 10 percent.

Rationale

Currently our ED provides an exemplary level of care to a diverse medical population. In order to prevent diabetes complications, patients need an alternative toward using the ED for primary care. We have selected this project to reduce complications associated with diabetes, reduce ED visits and readmissions, improve quality of life for this diverse populous, and eventually help them experience a better quality of life. This project addresses the gaps in care for the diabetic population and improves their knowledge of the disease process. Our milestones and metrics will guide us during the development of our diabetes program. In doing so, our team will use the Wagner Chronic Care Model to guide diabetes management plans. Our process includes: (1) Establishing a multidisciplinary team including Physicians, Nurse Practitioners, Diabetes Educators, Registered Dietitians, Clinical Social Workers, Registered Nurses, Pharmacists, and support staff. (2) Develop relationships with local agencies and physician offices to collectively develop and use care models for helping uninsured patients manage their diabetes. (3) Develop policies, procedures, and data collection tools to effectively run the coordinated program and monitor effectiveness, reducing fragmented care.

Project Components

The following core project components are included in this project: A) Design and implement a protocol that includes a multi-disciplinary team to help patients navigate the health care system. B) Ensure patients can access care teams by person, email or phone. C) Increase patient engagement through education, group visits, self-management support, improved patient-provider communication techniques, and coordination of community resources. D) Implement projects to empower patients to stay healthy and self-manage their diabetes. E) Conduct quality improvement for the project using methods such as rapid cycle improvement.

Unique community need identification numbers the project addresses:

- CN.1: Demographics
- CN.8: Chronic Disease
- CN.11: Emergency Department Usage and Readmissions

How the project represents a new initiative

This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures and Rationale:

IT-1.10: 1.10 Diabetes care: HbA1c poor control (>9.0%)

a. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or 2) who had hemoglobin Ac (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 2)

IT-3.3: Diabetes 30 day readmission rate

a. Numerator: number of readmissions (for patients 18 years and older), for any cause, within 300 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
b. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

Relationship to other Projects

This project relates to project 09410302.2.1 Establish/Expand Patient Care Navigation Program. The patient navigation program assists with the identification of at risk patient who might benefit from closer monitoring. The navigator would refer the patient to the Diabetes Program for management of their disease.

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

The safety net performing providers within RHP 9 have related projects to expand their chronic care management models and incorporate interventions for specific chronic disease or implement a disease registry. The following projects were identified:

Performing Provider	Unique Project ID	Project Option
Baylor University Medical Center	139485012.2.2	Expand Chronic Care Management Model
Baylor Medical Center at Garland	121790303.2.2	Expand Chronic Care Management Model

Baylor Medical Center at Irving	121776204.2.2	Expand Chronic Care Management Model
Trinity Medical Center (Baylor-Carrollton)	195018001.2.1	Expand Chronic Care Management Model
Children's Medical Center	138910807.1.3	Implement pediatric disease registry
Denton County HHS	13660803.2.1	Implement disease registry – diabetes
Methodist Charlton Medical Center	126679303.2.1	Expand Chronic Care Management Model
Methodist Dallas Medical Center	135032405.2.1	Expand Chronic Care Management Model
Methodist Richardson Medical Center	209345201.2.1	Expand Chronic Care Model
UTSW – Faculty Practice Plan	126686802.2.2	Expand Chronic Care Management Model

Texas Health Denton will also participate in this project and will be invited to participate in a learning collaborative. Members of the teams involved in leading similar chronic disease management projects would participate in the RHP-wide learning collaborative at least twice a year. Through participation in the collaborative, it is hoped that we would learn how to make our program more effective and to develop partnerships within the collaborative to improve efficiencies and patient outcomes.

We plan to play an active role in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Approach/Methodology: For every inpatient admission avoided, $8297 in cost is saved by the healthcare system.[389] Healthcare costs are calculated by multiplying $8297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs.

For every inpatient admission avoided, $8297 in cost is saved by the healthcare system.[390] Healthcare costs are calculated by multiplying $8297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

Rationale/Justification: Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g. if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that

[389] Based on 2011 historical inpatient diabetes admissions data for Texas Health Arlington Memorial
[390] Based on 2011 historical inpatient diabetes admissions data for Texas Health Arlington Memorial

already prevent avoidable inpatient admissions (e.g. keeping lower acuity patients under observation instead of admitting them).

Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g. if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g. keeping lower acuity patients under observation instead of admitting them).

Community benefits were calculated using the following factors: lost productivity (net of lost wages), work preseentism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using the following factors: lost wages, caretaker expense and extension of life (if applicable).

09410302.2.2	*2.2.1*	*2.2.1 (A-E)*	***TITLE:** REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES*
Texas Health Presbyterian Hospital Kaufman			*09410302*
Related Category 3 Outcome Measure(s):	*09410302.3.2* *09410302.3.3*	*3.IT-1.10* *3.IT-3.3*	*Diabetes care: HbA1c poor control (>9.0%)* *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-3]: Develop a comprehensive care management program Metric 1 [P-3.1]: Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and Institute of Chronic Illness Care's Assessment Model may be utilized in program development. Data Source: Creating planning documentation Goal: 2Q 2013 Metric 2 [P-3.2]:Increase the number of patients enrolled in a care management program over baseline Goal: 260 number of patients Data source: Program enrollment records Milestone 1 Estimated Incentive Payment: $19,739 **Milestone 2** [P-2]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinic and chronic disease care.	**Milestone 3** [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]: Increase the number of multi-disciplinary teams (e.g., teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams Data Source: Number of stakeholders educated Goal: 4Q 2013 Milestone 3 Estimated Incentive Payment: $19,112 **Milestone 4** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention. Metric 1 [P-9.1]: Increase the number of patients identified as needing screening test, preventative test, or other clinical services Goal: X number of patients receiving screenings	**Milestone 5** [I-17]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 1 [I-17.1]: 10 percent over baseline additional patients receive care under the Chronic Care Model for a chronic disease or MCC a) Diabetes Goal: 286 patients Data Source: Enrollment record Milestone 5 Estimated Incentive Payment: $40,315	**Milestone 6** [I-17]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 1 [I-17.1]: five percent additional patients receive care under the Chronic Care Model for a chronic disease or MCC a) Diabetes Goal: 300 patients Data Source: Patients enrolled Milestone 6 Estimated Incentive Payment: $32,552

09410302.2.2	*2.2.1*	*2.2.1 (A-E)*	***TITLE:** REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES*	
Texas Health Presbyterian Hospital Kaufman				*09410302*
Related Category 3 Outcome Measure(s):	*09410302.3.2* *09410302.3.3*	*3.IT-1.10* *3.IT-3.3*	*Diabetes care: HbA1c poor control (>9.0%)* *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)**
Metric 1 [P-2.1]:Increase percent of staff trained Goal: X percent of staff trained Data source: HR, training program materials Milestone 2 Estimated Incentive Payment: $19,740	Data source: clinic documentation Milestone 4 Estimated Incentive Payment: $19,112		
Year 2 Estimated Milestone Bundle Amount: $39,479*	Year 3 Estimated Milestone Bundle Amount: $38,224*	Year 4 Estimated Milestone Bundle Amount: $40,315	Year 5 Estimated Milestone Bundle Amount: $32,552
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $150,570			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Project Option 2.1.1 – Expanding the Medical Home Model in the UTSCAP Primary Care Network

Unique Project ID*:* 126686802.2.1
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center Faculty Practice Plan/126686802

Summary Information
Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds 452-beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, 24% of UTSW patient charges were attributed to Medicaid patients across Parkland, Children's and UT Southwestern.

Intervention(s): This project will expand the medical home model in the UTSCAP Network to enhance the delivery of primary care to our patients.

Need for the Project: The expansion of the UTSCAP Network to community physicians must also incorporate changes in how we care for patients. In order to improve the health of our Region and decompress the pressures on our Region's safety-net hospitals, we must implement a model of care that best serves our patients' primary care and preventive care needs.

Target Population: The target population for this project is all the UTSCAP Network patients (our patients) using primary care services. Approximately 3% of our patients are either Medicaid eligible or indigent, so we expect 3% of our medical home enrollees to be Medicaid eligible or indigent.

Category 1 or 2 Expected Patient Benefits: By DY5, the project aims to have increased the number of UTSCAP Network clinics using the medical home model by 10% and the number of medical home patients contacted for preventive services identified as necessary by 15% from the determined baseline. To benefit RHP 9 patients, UTSW intends to expand access to primary care resources and improve practice operations through this medical home initiative. Educating ER patients about the importance of primary care and empaneling patients with a PCMH inspired primary care provider can have a significant impact to RHP 9 patients. Thus, our expectation is that this program will have a substantial impact on a wide variety of patients in RHP 9. UTSW anticipates adding 126 primary care physicians to the Network. UTSW expects that by DY5 approximately 277,000 patients, including 44,000 Medicaid/low income patients, could benefit from this PCMH project. By implementing PCMH principles, these practices will directly impact the population for improved access, quality, and lower costs.

Category 3 Outcome Measures:

- IT-12.1 Breast Cancer Screening—Our goal is to increase the number of women aged 40 to 69 that have received an annual mammogram by X% (TBD) above the DY2 baseline.

- IT-12.3 Colorectal Cancer Screening—Out goal is to increase the number of adults aged 50 to 75 that have received colorectal cancer screening by X% (TBD) above the DY2 baseline.

- IT-12.4 Pneumonia Vaccination Status of Older Adults, age 65 and older—Out goal is to increase the number of patients who are older adults receiving a pneumonia vaccination by X% (TBD) over the DY2 baseline.

Project Description

UT Southwestern proposes to enhance the delivery of care provided through the Patient-Centered Medical Home (PCMH) model in the UTSCAP Primary Care Network.

This project, *Expanding the Medical Home Model in the UTSCAP Primary Care Network*, will provide support, resources and expertise in the patient centered medical home ("PCMH") model for affiliated community-based primary care physicians and practices to implement this model in their private practice. One of the key characteristics of the PCMH model is the rigorous measurement and ongoing quality analysis required to prove that appropriate care is being provided, thus reducing avoidable costs and improving patient outcomes.

The UTSCAP Primary Care Network (the "Network") is designed to integrate community-based primary care physicians and the faculty physicians of UT Southwestern Medical Center ("UT Southwestern"). The Network is in an early stage of development and growth and is actively recruiting community-based primary care physicians and their practices to join UT Southwestern faculty physicians. The ultimate goal of the Network is delivering patient care at the highest level of quality by the most cost-effective means, achieved through the clinical integration of Network physicians. Such outcomes are good for patients, payors, physicians and the community. The specific short and long-term goals for the Network include:

- Expanding, strengthening and implementing a clinically integrated network;
- Developing an infrastructure for effective care coordination of Network patients;
- Enhancing and continually developing a clinically integrated organizational structure in preparation of health care reform and value-based reimbursement; and
- Advancing the use of technology to improve health care and reduce medical errors.

As the Network grows through the membership of community-based primary care physicians, this project will develop, implement and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals

- Use evidence-based training materials for medical homes based upon model change concepts;
- Train medical home personnel on PCMH change concepts;
- Implement the medical home model in the Network's primary care clinics; and
- Provide population health management by identifying and reaching out to Network patients who need to be brought in for preventive service and ongoing coordinated care.

A major goal of the region is to provide improved access to coordinated primary and specialty care. This project would contribute to achieving that goal by implementing the principles of the PCMH model in an integrated primary care Network—the UTSCAP Network. In addition, emergency department utilization is high in RHP 9 and by providing more patients with the coordinated care they need, when they need it, this project helps achieve the a regional goal to keep patients from unnecessarily using the emergency departments and urgent care centers as a means to receive basic care.

Challenges

The implementation of the PCMH model represents a substantial evolution for physicians and patients. It requires significant investment in process redesign, systems implementation, provider education, software integration, communication, and patient research to ensure understanding and engagement toward the goals. Community-based primary care practices have limited resources to enable them to redesign their practice around the PCMH model. This project will allow affiliated, community-based primary care practices (i.e. UTSCAP Network clinics) with tight budgets the education, tools and resources to implement the difficult changes required of their practice necessary to realize the value of this care model. These transitions will be a significant challenge that can be met through this focused, planned invention for success. UT Southwestern will deploy resources to newly affiliated practices to assess the practices current processes, perform a gap analysis of where they are relative to PCMH standards, and provide an action plan of how to progress towards implementing PCMH principles.

5-Year Expected Outcome for Provider and Patients

The 5-year expected outcome for Network patients is improvement in increased incidence of preventative services actually delivered to patients and an improvement in quality metrics. The 5-year expected outcome for UT Southwestern is a clinically integrated network of affiliated

physicians successfully practicing under the PCMH model for the delivery of quality, efficient care, in preparation for healthcare reform.

In 2012, UT Southwestern Hospital – St. Paul had a total of 34,293 ER cases, of those cases 40% where provided to Medicaid/Charity/low income patients. Patients admitted through the ER had a substantially higher readmit rate than non-ER patients. In addtion, the percent of low income patients actually needing hospitalization was disproportionately low to all other patients who sought care in the ER. To benefit these and all RHP 9 patients, UTSW intends to expand access to primary care resources and improve practice operations through this medical home initiative. Educating ER patients about the importance of primary care and empaneling patients with a PCMH inspired primary care provider can have a significant impact to RHP 9 patients. Thus, our expectation is that this program will have a substantial impact on a wide variety of patients in RHP 9. UTSW anticipates adding 126 primary care physicians to the Network. UTSW expects that by DY5 approximately 277,000 patients, including 44,000 Medicaid/low income patients, could benefit from this PCMH project. By implementing PCMH principles, these practices will directly impact the population for improved access, quality, and lower costs.

Starting Point/Baseline

The starting point for this initiative is the level of PCMH clinic participation and implementation of the milestones and metrics described herein during the baseline period of October 1, 2010 – September 31, 2011. Currently, the UTSCAP Network contains one (1) primary care clinic that earned Level 3 recognition from the National Council for Quality Assurance (NCQA) PCMH Program in April 2011. This clinic is comprised of 32 primary care physicians. Thus, the baseline for this project is one (1) UTSCAP Network primary care clinic implementing the PCMH model of care delivery. Through the means described herein, UT Southwestern intends to expand implementation of PCMH in primary care practices materially over the baseline period.

Rationale

UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, UT Southwestern's faculty physician practice is one of the largest providers of physician services to the Medicaid program in Texas. For example, between December 2010 and November 2011, UT Southwestern physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices. Thus, UT Southwestern physician services are directly impacted by the negative outcomes created by inadequate access to efficient, quality primary care services for the patients in RHP 9.

This expansion of a clinically integrated network of community primary care physicians and clinics and the faculty physician practice at UT Southwestern must also incorporate changes in how care is delivered to patients. The Patient Centered Medical Home ("PCMH") is viewed as a foundation for delivering care that results in improvements in patient outcomes and better

cost-effectiveness. This project significantly enhances UT Southwestern's PCMH initiative by working with affiliated, community-based primary care clinics to expand the implementation of this model in the Network and our Region. Finally, the ultimate, predicted outcomes of this project are improved health of our Region's patients and decompression on the Region's safety-net hospitals.

Project Components

UT Southwestern's goal to create an affiliation of primary care clinics utilizing the PCMH model for the delivery of preventive services, such as colon cancer and pneumonia vaccinations, will ultimately result in a healthier community and a reduction in community resources spent on avoidable healthcare costs. While that is the ultimate goal, one of the first steps towards that goal is the expansion of the PCMH model across the Network. Through this project, we propose to meet all the required core elements: (1) utilizing a gap analysis to assess the UTSCAP Network's primary care physicians' NCQA PCMH readiness, (2) conducting feasibility studies to determine necessary steps to achieve NCQA PCMH status, (3) conducting educational sessions for UTSCAP Network primary care physicians', primary care practice offices, the UTSW University Hospital medical staff and leadership on the elements of PCMH, its rationale and vision; and (4) conducting quality improvement for the project using the method of rapid cycle improvement to identify the project impacts, "lessons learned", and identifying key challenges associated with expansion and sustainability of the PCMH model in the UTSCAP Network.

Unique community need identification number the project addresses

As indicated in the RHP 9 Community Needs Assessment, the demand for primary and specialty care services exceeds that of available medical physicians, thus limiting access to healthcare services for chronic disease management or preventive services. The specific and unique community need identification numbers that this project addresses include the following:

- CN.2-Regional Healthcare Infrastructure and Patient Migration Patterns
- CN.3- Healthcare Capacity
- CN.4-Primary Care and Pediatrics
- CN.12-ED Usage and Readmissions

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

The project represents a significant enhancement to the delivery of care through the PCMH model. Currently, the UTSCAP Network contains only one (1) primary care clinic that earned Level 3 recognition from the National Council for Quality Assurance (NCQA) PCMH Program in April 2011. With the growth of the UTSCAP Primary Care Network, UT Southwestern will engage community-based primary care physicians to deliver care under the PCMH principles of care; and thus, expand these principles throughout our Region.

Related Category 3 Outcome Measures

OD-12 Primary Care and Primary Prevention Outcomes:

- IT-12.1 Breast Cancer Screening (HEDIS 2012)
- IT-12.3 Colorectal Cancer Screening (HEDIS 2012)
- IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012)

Reasons/rationale for selecting the outcome measures:

Our expansion of the PCMH model and principles in the UTSCAP Network is aimed at connecting patients to their health care team that can proactively provide preventive, primary, routine and chronic care. We selected the above outcomes because implementing the principles of the PCMH should result in the increased incidence of preventative services actually delivered to patients. We subscribe to the theory that screening programs should lead to a cost-effective reduction in disease burden. UT Southwestern will focus on this outcome for all our attributed patients, irrespective of their socioeconomic status. As a result, we believe focusing on these outcomes will make a measurable difference for individuals in RHP 9 at all income levels.

Relationship to other Projects

The PCMH is the centerpiece for several planned UT Southwestern DSRIP projects. The PCMH is foundational to reaching our patient population in a low-cost setting while ensuring high quality, evidence-based care is delivered. The success of this initiative is highly dependent on the implementation of the following other projects proposed by UT Southwestern:

- ***126686802.1.2—Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics:*** This project improves access to primary care services by creating a robust Network of efficient, quality primary care physicians for RHP 9 patients. As community-based primary care physicians join the Network, they will no longer be practicing in "isolation".

- ***126686802.1.3—Implement a Quality Incentive Program for Network Primary Care Providers:*** UTSCAP Primary Care Network clinics will be able to participate in a quality incentive program. However, their ability to participate in this quality incentive program will be dependent upon their enrollment and participation in the Medicaid program, creating an environment whereby primary care physicians see all populations as a viable part of a broader patient population management program.

- ***126686802.1.4—Implement UT Southwestern Population Management Infrastructure Development:*** UTSCAP Primary Care Network clinics will provide services to Network

patients via a Network-wide population management infrastructure to improve quality and efficiency in the care they deliver.

- ***126686802.4—Implement/Expand Care Coordination Programs:*** UTSCAP Primary Care Network clinics will provide services to Network patients via access to the Network's care coordinators, ensuring that all Network patients receive coordinated, timely, and site-appropriate health care services.

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

Plan for Learning Collaborative:

The Anchor plans to develop and facilitate Learning Collaboratives in the Region with DFW Hospital Council. UT Southwestern will participate in the Collaborative(s) as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

   This project's score for this criteria: 3.65 X 2 = **7.3**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

   This project's score for this criteria: 3.5 X 2 = **7**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 3.5 X 2 = **7**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 3.5 X 2 = **7**

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 2.5 X 2 = **5**

Total Valuation Score for this project: **7**

These values are provided for in the table below and are allocated equally amongst the milestones.

126686802.2.1	*PROJECT OPTION 2.1.1*	*PROJECT COMPONENT(S) 2.1.1(A-D)*	*EXPANDING THE MEDICAL HOME MODEL IN THE UTSCAP PRIMARY CARE NETWORK*
UT Southwestern Medical Center Faculty Practice Plan			*126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.19* *126686802.3.20* *126686802.3.21*	*IT-12.1* *IT-12.3* *IT-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-8]: Develop or utilize evidence based training materials for medical homes based upon the model change concepts. Metric 1.1 [P-8.1]: Documentation of staff training materials. Baseline: Currently, UT Southwestern has not selected the necessary training materials Goal: Assess available evidence-based training materials, determine any gaps in such training materials and develop additional training resources as needed. Data Source: Training Materials. **Milestone 1 Estimated Incentive Payment: $ 725,465** **Milestone 2** [P-9]: Train UTSCAP Network medical home personnel on PCMH change concepts. Metric 2.1 [P-9.1]: Number of medical home personnel trained. Baseline: Zero (0) Goal: 1 or more medical home personnel trained. Data Source: UTSCAP Network Training records.	**Milestone 5** [P-1]: Implement the medical home model in primary care clinics. Metric 5.1 [P-1.1]: Increase the number of primary care clinics using the medical home model. Baseline: One (1) UTSCAP Network primary care clinic. Goal: Add 5 – 10 UTSCAP Network primary care clinics using the medical home model. Data Source: Documentation of the clinics' affiliation with UTSCAP Network and the implementation of PCMH principles. **Milestone 5 Estimated Incentive Payment: $ 1,062,200** **Milestone 6** [P-9]: Train medical home personnel on PCMH change concepts. Metric 5.1 [P-9.1]: Number of medical home personnel trained. Baseline: 1 Medical Home Staff Goal: 20-40more medical home personnel trained. Data Source: UTSCAP training	**Milestone 8** [P-1]: Implement the medical home model in primary care clinics. Metric 8.1 [P-1.1]: Increase the number of primary care clinics using the medical home model. Baseline: 5-10 Network primary care clinics using the medical home model at the end of DY3 Goal: Add 1-5 UTSCAP Network primary care clinics using the medical home model. Data Source: Documentation of the clinics' affiliation with UTSCAP Network and the implementation of PCMH principles. **Milestone 8 Estimated Incentive Payment: $681,784** **Milestone 9** [I-17]: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care. Metric 9.1 [I-17.1]: Reminders for patient preventive services.	**Milestone 13** [I-17]: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care. Metric 13.1 [I-17.1]: Reminders for patient preventive services. Baseline: Established and reported in DY2. Goal: 100% increase in the number of MH patients in the registry needing preventive service who have been contacted to come in for the service. Data Source: UTSCAP Network data systems, including EHR/PMS. **Milestone 13 Estimated Incentive Payment: $658,729** **Milestone 14** [I-16]: Increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home. Metric 14.1 [I-16.1]: Percent of primary care visits at medical home. Baseline: Number of enrolled patients'

126686802.2.1	*PROJECT OPTION 2.1.1*	*PROJECT COMPONENT(S) 2.1.1(A-D)*	*EXPANDING THE MEDICAL HOME MODEL IN THE UTSCAP PRIMARY CARE NETWORK*	
UT Southwestern Medical Center Faculty Practice Plan				*126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.19* *126686802.3.20* *126686802.3.21*	*IT-12.1* *IT-12.3* *IT-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 2 Estimated Incentive Payment: $ 725,465 **Milestone 3** [P-X]: Establish the baseline of the UTSCAP Network's medical home reminders for patient preventive services. Metric 2.1 [P-X.1]: Establish baseline Baseline/Goal: Documentation of the Network's medical home baseline for reminders for patient preventive services. Data Source: UTSCAP Network data systems, including EHR/PMS. **Milestone 3 Estimated Incentive Payment: $ 725,465** **Milestone 4** [I-17]: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care. Metric 4.1 [I-17.1]: Reminders for patient preventive services. Baseline: Established in Milestone 3. Goal: Implement a structured process/program to reach out to MH	records. **Milestone 6 Estimated Incentive Payment: $ 1,062,200** **Milestone 7** [I-17]: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care. Metric 7.1 [I-17.1]: Reminders for patient preventive services. Baseline: Established and reported in DY 2. Goal: 20% increase in the number of MH patients in the registry needing preventive service who have been reach out to for scheduling the service. Data Source: UTSCAP Network data systems, including EHR/PMS. **Milestone 7 Estimated Incentive Payment: $ 1,062,200**	Baseline: Established and reported in DY 2. Goal: 75% increase in the number of MH patients in the registry needing preventive service who have been reach out to for scheduling the service.. Data Source: UTSCAP Network data systems, including EHR/PMS. **Milestone 9 Estimated Incentive Payment: $681,784** **Milestone 10** [P-9]: Train medical home personnel on PCMH change concepts. Metric 10.1 [P-9.1]: Number of medical home personnel trained. Baseline: 20-40 personnel trained in PCMH change concepts by the end of DY3 Goal: 10-20 more medical home personnel trained. Data Source: UTSCAP training records. **Milestone 10 Estimated Incentive Payment: $681,784**	primary care visits with medical home primary care provider/team during DY3. Goal: 5% increase in the number of MH patients who seeing MH provider/team in lieu of non-MH PCP provider. Data Source: UTSCAP Network data systems, including HER/PMS or other documentation as designated by Performing Provider. **Milestone 14 Estimated Incentive Payment: $658,729** **Milestone 15** [P-9]: Train medical home personnel on PCMH change concepts. Metric 15.1 [P-9.1]: Number of medical home personnel trained. Baseline: 30-60 personnel trained in PCMH change concepts by the end of DY4. Goal: 10-20 more medical home personnel trained. Data Source: UTSCAP training records. **Milestone 15 Estimated Incentive Payment: $658,729**

126686802.2.1	*PROJECT OPTION 2.1.1*	*PROJECT COMPONENT(S) 2.1.1(A-D)*	*EXPANDING THE MEDICAL HOME MODEL IN THE UTSCAP PRIMARY CARE NETWORK*	
UT Southwestern Medical Center Faculty Practice Plan				*126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.19* *126686802.3.20* *126686802.3.21*	*IT-12.1* *IT-12.3* *IT-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)**
patients in need of preventive services. Data Source: Documented implementation plan and/or executed vendor agreement. **Milestone 4 Estimated Incentive Payment: $ 725,464**		**Milestone 11** [I-16]: Increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home. Metric 11.1 [I-16.1]: Percent of primary care visits at medical home. Baseline: Number of enrolled patients' primary care visits with medical home primary care provider/team during DY3. Goal: 5% increase in the number of MH patients who seeing MH provider/team in lieu of non-MH PCP provider. Data Source: UTSCAP Network data systems, including HER/PMS or other documentation as designated by Performing Provider. **Milestone 11 Estimated Incentive Payment: $681,784** **Milestone 12** [I-15]: Increase the number or percent of medical home patients that are able to identify their usual source of care as being managed in medical homes Metric 12.1 [I-15-1]: Usual source of	**Milestone 16** [I-12]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric 16.1 [I-12.1]: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the performing provider. Baseline: Number of eligible patients assigned to a medical home in DY4. Goal: 5% increase Data Source: Practice management system, EHR, or other documentation as designed by performing provider **Milestone 16 Estimated Incentive Payment: $658,729** **Milestone 17** [I-18]: Obtain medical home recognition by a nationally recognized agency. The level of medical home recognition will depend on the practice baseline and accrediting agency. Metric 17.1 [I-18.1] Medical home recognition/accreditation Baseline: Number of sites or

126686802.2.1	*PROJECT OPTION 2.1.1*	*PROJECT COMPONENT(S) 2.1.1(A-D)*	*EXPANDING THE MEDICAL HOME MODEL IN THE UTSCAP PRIMARY CARE NETWORK*
UT Southwestern Medical Center Faculty Practice Plan			*126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.19* *126686802.3.20* *126686802.3.21*	*IT-12.1* *IT-12.3* *IT-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)**
		care Baseline: Number of medical home patients that are able to identify their medical home as their usual source of care in DY3. Goal: 5% increase over baseline. Data Source: Patient survey results. **Milestone 12 Estimated Incentive Payment: $681,785**	clinics receiving recognition/accreditation in DY3. Goal: 10 accreditations above baseline. Data Source: Documentation of recognition/accreditation from nationally recognized agency. **Milestone 17 Estimated Incentive Payment: $658,728**
Year 2 Estimated Milestone Bundle Amount: **$2,901,859**	Year 3 Estimated Milestone Bundle Amount: **$3,186,600**	Year 4 Estimated Milestone Bundle Amount: **$3,408,921**	Year 5 Estimated Milestone Bundle Amount: **$3,293,644**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: **$12,791,024**			

Project Option 2.8.1 – Applying process improvement methodology to improve quality and efficiency by training in the methodology of quality improvement
Project Title: Expand an existing, successful advanced training program in quality improvement methodology

Unique Project ID: 126686802.2.2
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center Faculty Practice Plan/126686802

Summary Information
Provider: The UT Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds in the St. Paul and Zale Lipshy Hospitals, and 40 clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 inpatients and oversee nearly 2 million outpatient visits/year. UTSW physicians provide a majority of at Parkland Hospital and Children's Medical Center. As a result, the UTSW Faculty Practice Plan is one of the largest Medicaid providers for in Texas. For example, between December 2010 and November 2011, UTSW physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UTSW outpatient practices.

Intervention(s): This project will expand an existing, successful advanced quality/process improvement training program in quality improvement methodology.

Need for the Project: The expansion of our advanced training program will allow healthcare providers from outside of UT Southwestern, students/trainees of UT Southwestern, and UT Southwestern affiliated institutions to participate in these training program, which will produce PI Events/Projects that will product significant cost savings and/or cost avoidance.

Target Population: The target population includes the clinical staff at 3 Performing Providers, including UT Southwestern Medical Center, Parkland Hospital, and Children's Medical Center, who treat patients (including our patients). By improving the quality improvement skills of the target population, they can in turn improve the care provided and the outcomes that come from the improvements.

Category 1 or 2 Expected Patient Benefits: Increase the number of physicians and clinical staff trained each year from 100 to 150. By DY5, the project seeks to have increased the number of Process Improvement Champions from 5/year to 20/Year. Increase the number of PI Projects conducted each year by 10% over the baseline established in DY2, increasing the potential for cost savings and cost avoidance each year. Create a method to measure cost savings from PI Events/Projects to reinforce the value of the training and PI project outcomes. It is estimated that the value of PI projects will be at least $4 -$8 million per year by DY5. PI Champions are defined as graduates from the program involved in future projects as facilitators. The patients affected by this project will be all patients seen at the 3 institutions. Any quality improvement

project done by any of the participants in this course including the Category 3 projects will affect patients in multiple areas, improving outcomes and lowering costs.

Category 3 Outcome Measures:

- IT-1.10 Diabetes Care: HbA1C—Our goal is to decrease the number of patients with diabetes who had a HbA1c greater than 9.0% by X% (TBD) over the DY2 baseline.

- IT-3.1 All cause 30 day readmission rate—Our goal is to reduce the 30 day potentially preventable all-cause readmission rate by X% (TBD) over the DY2 baseline.

Project Description

UT Southwestern proposes to expand an existing, successful advanced training program in quality improvement methodology.

UT Southwestern currently has a program that provides advanced training in this methodology to physicians and staff of its University Hospitals and Clinics, Parkland Health and Hospital System and Children's Medical Center at Dallas, i.e. the Southwestern Medical District.

This project will have two parts. First, UT Southwestern will expand the capacity of its current **Clinical Safety & Effectiveness Course** to provide advanced training in the methodology of Continuous Quality Improvement (CQI). The eligibility to take this Course will be expanded to include providers outside UT Southwestern and within the UTSCAP Network, medical and allied health students, and residents/fellows of training programs from UT Southwestern Affiliated Institutions. Second, a methodology to accurately evaluate the effectiveness and outcomes of this type of advanced training will be developed. Currently, the effectiveness of this program is measured by the number of projects completed by participants, the estimated avoidable costs savings by each project and the number of participants. A more advanced methodology of tracking and evaluating the quality of projects done by participants during the program course and after graduation is needed and will be developed.

The curriculum of the training program is comprehensive and includes the following areas:

(1) After completing the course, each participant will understand and be able to discuss:

- Case for continuous quality improvement
- Definition of clinical quality and who defines it?
- Voice of the Customer (VOC) and quality lessons from industry
- Current state of medical quality in the United States and UT Southwestern
- Use of PDCA and DMAIC as process improvement tools
- Team composition, management and dynamics
- Aim statement, project charter, scope and timeline
- Critical to quality tree, prioritization matrices and Kano's model
- Paradigm Shifts, Change Management, and Change Acceleration Process
- Equitable medical care and public health policy
- Process mapping and SIPOC
- Lean management tools
- Root cause analysis
- Data types and collection
- The use of HIT to evaluate and improve clinical care

(2) After completing the course, each participant will understand and be able to use the following quality improvement tools:

- Check list

- Histogram
- Pareto chart
- Fishbone diagram
- Root Cause Analysis
- Scatter plot
- Run chart
- SPC or control chart
- FMEA

(3) After completing the course, each participant will understand the following concepts:

- Central tendency, standard deviation, process capability
- Confidence and probability
- Common and special cause variation
- Distribution and sampling
- Correlation and causation

(4) After completing the course, each participant will be able to develop, perform and report a quality improvement project using the PDCA Cycle.

The project will have other components that meet the project requirements. Participating hospitals and systems will work with the project leaders to be sure the following elements are part of their performance improvement programs:

a) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.
b) Define key safety, quality, and efficiency performance measures and develop a system for continuous data collection, analysis and dissemination of performance on these measures (i.e. weekly or monthly dashboard).
c) Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement.
d) Implement software to integrate workflows and provide real-time performance feedback.
e) Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change processes based on the result of key performance indicators.

The target patient population is the population of patients cared for by the 3 Health Systems of the UT Southwestern Campus. This includes UT Southwestern University Hospitals, Parkland

Health and Hospital System and Children's Medical Center. The Course will be offered to the faculty of UT Southwestern which provides care at all of these hospitals and the staff of all of the participating hospitals. Currently the Course is offered to these institutions and the expansion of the project will include all three institutions and systems. The patients affected by this project will be all patients seen at these institutions since the faculty provide care there. The faculty provided care to 274,489 charity and Medicaid visits from December 2010 and November 2011 and the entire population should benefit from this course.
The project will not be funded through a collaboration agreement.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals
The long-term, primary goal of this project is to train and education clinical and administrative staff on process improvement strategies, methodologies, and culture so that clinical outcomes and efficiencies will improve. The project goals are as follows:

- Expand the capacity of its current **Clinical Safety & Effectiveness Course** to provide advanced training in the methodology of Continuous Quality Improvement (CQI);

- Develop a methodology to accurately evaluate the effectiveness and outcomes of this type of advanced training

A major goal of the region is to reduce the unnecessary utilization in the Emergency Departments and reduce unnecessary readmission rates. This project will contribute to that goal by providing RHP 9 providers with the tools needed to provide quality care that is safe and efficient.

Challenges
Expanding the current system poses several immediate challenges. First, the cost of training providers is significant. Each participant in the training program completes 7 full days of didactic and participation sessions spread over 5 month period and a quality improvement project that is presented on the 8th day of the course. In addition, each participant receives 8 quality improvement textbooks. Finally several nation speakers who are experts in quality improvement methodology and leadership present to each class. Second, the time commitment by each participant is much more than the 8 days of didactic work. Each has to complete an outside quality improvement project that is relevant to their area of expertise. Finally, expanding the program to include providers outside of the UT system will present special challenges such as data sharing and marketing of the program.

To address these challenges and create a successfully expanded program, UT Southwestern will create a marketing strategy to attract participants from the rest of Region 9, targeting Parkland

Health and Hospital District, Children's Medical Center and Texas health Resources. We will continue to furnish current materials to these participants and the same curriculum and faculty

5-Year Expected Outcome for Provider and Patients

Increase the number of physicians and clinical staff trained each year from 100 to 150. By DY5, the project seeks to have increased the number of Process Improvement Champions from 5/year to 20/Year. Increase the number of PI Projects conducted each year by 10% over the baseline established in DY2, increasing the potential for cost savings and cost avoidance each year. Create a method to measure cost savings from PI Events/Projects to reinforce the value of the training and PI project outcomes. It is estimated that the value of PI projects will be at least $4 -$8 million per year by DY5. PI Champions are defined as graduates from the program involved in future projects as facilitators. The patients affected by this project will be all patients seen at the 3 institutions. Any quality improvement project done by any of the participants in this course including the Category 3 projects will affect patients in multiple areas, improving outcomes and lowering costs.

Starting Point/Baseline

The current program trains about 100 participants per year. This program was started 2.5 years ago and to date has trained over 250 faculty and staff, including more than 50 physicians. These trainees have done more than 50 quality improvement projects with several million dollars of estimated avoidable costs due to providing safer and more efficient care. These savings could be multiplied if this program were expanded to reach more providers and staff both inside and outside the UT Southwestern campus.

Rationale

Healthcare in the United States is expensive and the quality of the care delivered is in need of re-engineering to become a safer and more efficient system. One method of improving the quality of care delivered by providers is to educate members of the health care team in the methodology of process improvement. UT Southwestern has a long history in the education of future care providers; thus, this project of training providers in the methods and culture of quality improvement directly supports our mission of teaching.

Project Components

This project is related to the regional goals of the RHP in that quality improvement is considered a critical component of most of the projects in the regional plan. This project will provide advanced training in the methodology of quality improvement, including PDCA, and rapid cycle improvement. This project is scalable to provide education to all members of the regional plan who desire advance training in the methodology of Quality Improvement.

Specify the unique community need identification number the project addresses:

- CN.11 Patient Safety and Quality
- CN.12 Emergency Department Usage and Readmissions

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

This project, although not new to UT Southwestern, significantly enhances the UT Southwestern's and RHP 9's ability to create a cultural change within the region towards quality improvement.

Related Category 3 Outcome Measures:

Patients in multiple systems with any diseases affected by projects of graduates for this program will benefit. However, we have chosen the below conditions due to their high risk and prevalence and high cost impact on the health care system as illustrations of the benefits seen by patients from the graduates of this program.

OD-1 Primary Care and Chronic Disease Management:

- IT-1.10 Diabetes care: HbA1c poor control (>9.0%)

OD-3 Potentially preventable Re-Admissions- 30 day Readmission Rates

- IT-3.1 All cause 30 day readmission rate

Reasons/rationale for selecting the outcome measures

We selected a standalone measure from the domain of potentially preventable re-admission rates, because this is one of the clinical outcomes measures that should be impacted by the refinement and expansion our project resulting in improved lives of our patients and reducing unnecessary health care costs. In addition, we selected a standalone measure to access the control of diabetes in our patients. 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. 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. Thus, we selected diabetes care as an additional outcome measure because of the prevalence of diabetes in our region.

UT Southwestern will be focusing on these outcomes for all our attributed patients, irrespective of their socioeconomic status. As a result, we believe focusing on these outcomes will make a measurable difference towards transforming the delivery of care in our region and make a difference in the lives of individuals in our community and in RHP 9 at all income levels.

Relationship to other Projects

Quality improvement is a fundamental component of UT Southwestern's DSRIP projects and knowledge of the methodology of quality improvement is critical to the success of all of these projects:

- ***126686802.1.2—Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics & Affiliated, Community Primary Care Clinics:***

This project improves access to primary care services by creating a Network of primary care physicians. As community-based primary care physicians join the Network, they will no longer be practicing in "isolation". Through clinical integration with UT Southwestern, these community-based physicians will engage in the continual development and implementation of clinical "best practice" protocols.

- ***126686802.1.3—Implement a Quality Incentive Program for Network Primary Care Providers:*** UTSCAP Primary Care Network clinics will be able to participate in a quality incentive program. However, their ability to participate in this quality incentive program will be dependent upon their enrollment and participation in the Medicaid program.

- ***126686802.1.4—Implement UT Southwestern Population Management Infrastructure Development:*** UTSCAP Primary Care Network clinics will provide services to Network patients via a Network-wide population management infrastructure to improve quality and efficiency in the care they deliver.

- ***126686802.2.4—Implement/Expand Care Coordination Programs:*** UTSCAP Primary Care Network clinics will provide services to Network patients via access to the Network's care coordinators, ensuring that all Network patients receive coordinated, timely, and site-appropriate health care services.

Related Category 4 Population-focused improvements

RD-2: Potentially Preventable Readmissions

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

Parkland Health & Hospital System: 127295703.2.6
Denton Regional Medical Center: 111905902.2.1
Medical Center of Lewisville: 094192402.2.2
Medical City Dallas Hospital: 020943901.2.3

We plan to play active leadership and participant roles in the development and ongoing conduct of Project Learning Collaboratives, appropriate to our project, as organized by RHP 9 and described in Section IV – Stakeholder Engagement. We will also participate in any Outcomes Learning Collaborative that is associated with the outcomes of this project to obtain additional perspectives that may enable us to improve this project. We believe that the exchange of best practices and shared learning contributes significantly to continuous quality improvement and will advance the success of this project.

Project Valuation

Because the faculty of UT Southwestern provides care to patients in the UT Southwestern, Parkland Health and Hospital System and Children's Medical Center and all of the employees of

these systems are eligible to take this course, all of the patients in these systems, including the Medicaid and charity, will benefit. This includes 274,489 Medicaid and charity patient visits from Dec 2010 through November 2011 at these three institutions.

In addition, significant cost avoidance has already been demonstrated by graduates of this program. Since its beginning in 2010, over 50 quality improvement projects have been completed. Three of these projects alone accounted for more than $1.5M in cost avoidance at the UT Southwestern University Hospitals.

The Anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using those criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criteria: 4.5 X 2 = 9.0

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population. This project's score for this criteria: 4.5 X 2 = 9.0

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues. This project's score for this criteria: 4.5 X 2 = 9.0

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person. This project's score for this criteria: 4.5 X 2 = 9.0

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability. This project's score for this criteria: 4.5 X 2 = 9.0

6. Partnership collaboration (Weight 5%): 4.5 X 2 = 9.0

Total Valuation Score for this project: **9.0**

126686802.2.2	**PROJECT OPTION 2.8.1**	***PROJECT COMPONENT(S) 2.8.1 (A-F)***	Applying process improvement methodology to improve quality and efficiency by training in the methodology of quality improvement	
Performing provider: The University of Texas Southwestern Medical Center				TPI 126686802
Related Category 3 Outcome Measure(s):	126686802.3.22 126686802.3.23	IT-1.10 IT-3.1	Diabetes care: HbA1c poor control (>9.0%) 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-6]: Implement a program to improve efficiencies and/or reduce program variation. Metric 1.1 [P-6.1]: Performance improvement events/projects as defined above, establishing baseline number of events Baseline: No data available. Goal: Establish baseline Data Source: Administrative records of Office of Quality Improvement and Safety; follow-up with students trained. **Milestone 1 Estimated Incentive Payment: $400,256** **Milestone 2** (P-8): Train providers/staff in process improvement Metric 2.1 (P-8.1): Number of providers/staff trained Baseline: 100/year in 2011 Goal: 125/year Numerator: Number of providers/staff trained Denominator: Total number of providers/staff Data Source: Administrative records **Milestone 2 Estimated Incentive**	**Milestone 5** (P-8): Train providers/staff in process improvement Metric 5.1 (P-8.1): Number of providers/staff trained Baseline: 125 trained per year Goal: 150/year Numerator: Number of providers/staff trained Denominator: Total number of providers/staff Data Source: Administrative records **Milestone 5 Estimated Incentive Payment: $439,531** **Milestone 6** [P-6]: Implement a program to improve efficiencies and/or reduce program variation. Metric 6.1 [P-6.1]: Performance improvement events/projects as defined above and establish baseline number of events Baseline: Determined in DY2 Goal: Increase number of PI events by 10% over DY2 Data Source: Administrative records of Office of Quality Improvement and Safety	**Milestone 9** (I-15): Increase the number of process improvement champions Metric 9.1 (I-15.1) Number of designated quality champions Baseline: 15 Goal: 20 designated PI Champions Data Source: HR, or training curriculum or other program materials Rationale/Evidence: Part of process improvement is implementing a culture change oriented toward continuous performance improvement **Milestone 9 Estimated Incentive Payment: $626,928** **Milestone 10**[P-6]: Implement a program to improve efficiencies and/or reduce program variation. Metric 10.1 [P-6.1]: Performance improvement events as defined above and establish baseline number of events Baseline: Determined in DY2 Goal: Increase number of PI events by 10% over DY3	**Milestone 12** (I-15): Increase the number of process improvement champions Metric 12.1 (I-15.1) Number of designated quality champions Baseline: 15 Goal: 20 designated PI Champions. Data Source: HR, or training curriculum or other program materials Rationale/Evidence: Part of process improvement is implementing a culture change oriented toward continuous performance improvement **Milestone 12 Estimated Incentive Payment: $605,937** **Milestone 13**[P-6]: Implement a program to improve efficiencies and/or reduce program variation. Metric 13.1[P-6.1]: Performance improvement events as defined above and establish baseline number of events Baseline: Determined in DY2 Goal: Increase number of PI events by 10% over DY4

126686802.2.2	**PROJECT OPTION 2.8.1**	***PROJECT COMPONENT(S) 2.8.1 (A-F)***	Applying process improvement methodology to improve quality and efficiency by training in the methodology of quality improvement	
Performing provider: The University of Texas Southwestern Medical Center				TPI 126686802
Related Category 3 Outcome Measure(s):	126686802.3.22 126686802.3.23	IT-1.10 IT-3.1	Diabetes care: HbA1c poor control (>9.0%) 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)**
Payment: $400,256 **Milestone 3** (I-15): Increase the number of process improvement champions Metric 3.1 (I-15.1) Number of designated quality champions Baseline: Data not previously collected. Goal: 10 designated PI Champions in DY2 Data Source: HR, or training curriculum or other program materials Rationale/Evidence: Part of process improvement is implementing a culture change oriented toward continuous performance improvement **Milestone 3 Estimated Incentive Payment: $400,257** **Milestone 4 [I-14]:** Measure efficiency of cost. **Metric 4.1 [1-14.1]:** Develop a tool (software-based) to measure the impact on cost-avoidance or cost-savings achieved by the events/projects	**Milestone 6 Estimated Incentive Payment: $439,531** **Milestone 7** (I-15): Increase the number of process improvement champions Metric 7.1 (I-15.1) Number of designated quality champions Baseline: 10 Goal: 15 designated PI Champions. Data Source: HR, or training curriculum or other program materials Rationale/Evidence: Part of process improvement is implementing a culture change oriented toward continuous performance improvement **Milestone 7 Estimated Incentive Payment: $439,531** **Milestone 8 [I-14]:** Measure efficiency of cost. **Metric 8.1 [1-14.1]:** Implement the tool to measure PI Project/Event cost avoidance, developing a baseline of what projects are achieving. **Baseline**: N/A **Goal**: Successfully test the tool and		Data Source: Administrative records of Office of Quality Improvement and Safety **Milestone 10 Estimated Incentive Payment: $626,928** **Milestone 11 [I-14]:** Measure efficiency of cost. **Metric 11.1 [1-14.1]:** Documented cost savings or cost avoidance. **Baseline**: DY3 Cost savings and avoidance data. **Goal**: 10% increase over DY3 **Data Source**: Project reports and documented analyses on completed projects. **Milestone 11Estimated Incentive Payment: $626,928**	Data Source: Administrative records of Office of Quality Improvement and Safety **Milestone 13 Estimated Incentive Payment: $605,938** **Milestone 14 [I-14]:** Measure efficiency of cost. **Metric 14.1 [1-14.1]:** Documented cost savings or cost avoidance. **Baseline**: DY4 Cost savings and avoidance data. **Goal**: 10% increase over DY4 **Data Source**: Project reports and documented analyses on completed projects. **Milestone 14 Estimated Incentive Payment: $605,938**

126686802.2.2	PROJECT OPTION 2.8.1	*PROJECT COMPONENT(S) 2.8.1 (A-F)*	Applying process improvement methodology to improve quality and efficiency by training in the methodology of quality improvement	
Performing provider: The University of Texas Southwestern Medical Center				TPI 126686802
Related Category 3 Outcome Measure(s):	126686802.3.22 126686802.3.23	IT-1.10 IT-3.1	Diabetes care: HbA1c poor control (>9.0%) 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)**
conducted by course trainees and PI Champions. **Baseline**: N/A **Goal**: Produce a tool to measure PI Event/Project cost avoidance or savings outcomes. **Data Source**: Documentation and working model of the tool. **Rationale**: By creating a tool to measure the effectively of PI projects, it will be easier to motivate more people to participate in learning, and it will show the value of doing PI projects. **Milestone 4 Estimated Incentive Payment: $400,257**		develop a baseline of outcome data for various projects. **Data Source**: Project reports and documented analyses on completed projects. **Milestone 8 Estimated Incentive Payment: $439,531**		
Year 2 Estimated Milestone Bundle Amount: $1,601,026		Year 3 Estimated Milestone Bundle Amount: $1,758,124	Year 4 Estimated Milestone Bundle Amount: $1,880,784	Year 5 Estimated Milestone Bundle Amount: $1,817,813
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $7,057,117				

Project Option 2.5.1 - UT Southwestern Ambulatory Practice: Redesigning for cost containment

Unique Project ID: 126686802.2.3
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW") Faculty Practice Plan/ TPI 126686802

Summary Information
Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, UTSW physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices.

Intervention(s): This project will implement a cost accounting system that will provide reasonable, consistent and accepted costing of services in order to measure cost improvement or containment for the health care services we provide.

Need for the Project: In our ambulatory (faculty practice), we currently do not have a cost accounting system that allows us to address the real costs and their allocation for analysis.

Target Population: The target population for this project is all our patients. Approximately 3% of our patient clinic visits are either Medicaid eligible or indigent. Approximately 12,663 ED encounters are Medicaid and indigent, accounting for 45.9% of those encounters overall. Approximately 16,175 Medicaid patients visits were seen in UTSW outpatient clinics.

Category 1 or 2 Expected Patient Benefits: By DY5, we will have implemented a cost accounting system for our faculty practice, conducted a cost analysis and measured cost containment by re-measuring the healthcare costs of an intervention and comparing to the baseline in order to gauge improvements in cost.

Category 3 Outcome Measures:

OD-5 Redesign for Cost Containment
IT-5.1 Develop an integrated care model with outcome-based payments.

Project Description:

UT Southwestern proposes to implement a cost accounting system that will provide reasonable, consistent and accepted costing of services in order to measure cost improvement or containment for the health care services we provide.

The UT Southwestern Medical Service Research & Development Plan (UTSW-MSRDP) has struggled with cost accounting for years. Extremely limited resources and our continuing patient growth have required that we focus resources away from administrative areas to support clinical functions. Thus, UTSW-MSRDP has had to rely on basic cost to charge ratios that may work at a global (departmental) level but can provide very inaccurate or inconsistent results at a specific service or provider level due to variations in individual cost to charge comparisons. Consequently, providers, department managers and executives within the institution do not understand where the numbers come from and therefore place little faith in the resultant calculations. Finance and Planning staff have to make many assumptions and calculations in an attempt to address the real costs and their allocation for each analysis, creating inefficiencies and long turn-around times.

Studies have shown that access to primary care and chronic care management help reduce the need for high cost emergency care and hospitalizations (Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q.* 2005;83(3):457-502). Innovations that improve quality and integration add to cost management. We need the ability to accurately measure and monitor this improvement, and educate our providers of the cost impacts of the decisions they make. This requires investing in a system that will allow us to measure and monitor the impacts of our initiatives on the cost of healthcare.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationships to Regional Goals:

The project goals are as follows:

- Determine the best cost-accounting methodology to quantify the financial impact of quality and efficiency improvement interventions.
- Provide our finance staff with the necessary training to implement the selected cost-accounting methodology.
- Implement the cost-accounting methodology and related systems to measure intervention impacts.
- Engage in quality improvement activities for the project to ensure that the best possible project outcomes are achieved.
- Conduct a cost analysis for the majority of services we provide.

- Measure cost containment by re-measuring healthcare costs of an intervention and compare to baseline to gauge improvements in cost.

This project also meets the following regional goals:

Our region has a significant issue with capacity and access to primary care, specialty care and chronic disease management. One way of increasing these capacities to create efficiencies in the cost of care provided. As the system is more efficient in delivering care, the more care the system can deliver. A goal of RHP 9 is to provide quality, efficient, cost effective healthcare services to patients of RHP 9 at the right time, the right place and the right setting.

Challenges:

Analysis of physician outcome data, treatment data and cost data can inform the assessment of quality and efficiency for health episodes of care, which reflect all of the visits, procedures, testing and drugs used to treat a health "episode". UTSW anticipates spending a significant amount of time working with the selected Cost Accounting System vendor to try and accurately assign costs of care across all aspects of the health "episode". Given the complexity and variable nature of the provision of health care services, this process will be extremely challenging and will require significant effort and time investment by various departments across the UTSW organization.

5-Year expected outcomes for providers and patients:

The target population for this project is all our patients. Approximately 3% of our patient clinic visits are either Medicaid eligible or indigent. Approximately 12,663 ED encounters are Medicaid and indigent, accounting for 45.9% of those encounters overall. Approximately 16,175 Medicaid patients visits were seen in UTSW outpatient clinics. The ability for UT Southwestern to appropriately allocate resources to improve care resources and availability will greatly enhance access and results of the care provided at UT Southwestern facilities. Accurately tracking and assigning costs to specific service lines/clinics will allow us a greater understanding of the true underlying costs of care.

Starting Point/Baseline:

UTSW-MSRDP has had to rely on basic cost to charge ratios that may work at a global (departmental) level but can provide very inaccurate or inconsistent results at a specific service or provider level due to variations in individual cost to charge comparisons. Thus, the baseline for the activities required to complete this project are zero (0).

Rationale:

Pressures continue to be put on all our revenue sources from private payers, Medicaid, Medicare and State budgets, all of which negatively impact the resources available to meet patient demand. At the same time, the need for access to care continues to grow. The only way for institutions like UT Southwestern to meet these demands is to continue to become more efficient and effective at managing our finite resources. UTSW-MSRDP's mission is to build the necessary infrastructure and redesign to provide improved access, care management,

integration and quality. There is also an expectation that UTSW-MSRDP will also contain costs. To this end, we need to develop systems to measure and monitor our initiatives impact on costs. Therefore, the goal is to develop the capability to measure cost containment and apply that to projects or efforts so that the ability to measure the efficacy of initiatives is in place.

Project Components:

Through the Health Care Navigation Program, we propose to meet all the required project components:

(a) Implement a cost-accounting system to measure intervention impacts,

(b) Establish a method to measure cost containment,

(c) Establish a baseline for cost, and

(d) Measure cost containment.

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

While hospitals are generally accustomed to having robust cost accounting systems, such systems have been lacking on the Physician Practice side. Consequently, we do not have a good understanding of the true cost of providing care. This effort to implement a new cost accounting system is to correct that situation by providing us a system specifically designed to provide accurate information about the true costs of providing care through a large Faculty based practice.

Community Needs Addressed:

The specific and unique community need identification numbers that this project addresses include the following:

- CN.3-Healthcare Capacity
- CN.4-Primary Care and Pediatrics
- CN.8- Specialty Care
- CN.9-Chronic Disease
- CN.11-Patient Safety and Quality

Related Category 3 Outcome Measure(s):

OD-5 Redesign for Cost Containment

IT-5.1 Develop an integrated care model with outcome-based payments.

Relationship to other Projects:
Accurately tracking and assigning costs to specific service lines/clinics will allow UT Southwestern to appropriately allocate resources to improve care resources and availability. Having a greater understanding of the true underlying costs of care will also allow us to more accurately assess the success of other expansion projects currently being proposed under Waiver proposal.

- 126686802.2.2.2—Applying process improvement methodology to improve quality and efficiency by training in the methodology of quality improvement
- 126686802.1.1.2—Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinic
- 126686802.2.1.1—Expanding the Medical Home Model in the UTSCAP Primary Care Network
- 86802.1.10.2—Implement UT Southwestern Population Management Infrastructure Development
- 126686802.2.9.1—Implement/Expand Care Coordination Programs
- 126686802.2.12.1—Expanding Care Transition Programs

Relationship to Other Performing Providers' Projects in the RHP: Parkland Health & Hospital System is the only other Performing Provider that has elected to conduct a Category 2.5 project. They have chosen Ouome Measure 2.5.2.

Plan for Learning Collaborative: The Anchor plans to develop and facilitate Learning Collaboratives in the Region. UT Southwestern will participate in the Collaboratives as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation:
The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following

exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

   This project's score for this criteria: 2 X 2 = **4**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

   This project's score for this criteria: 2 X 2 = **4**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

   This project's score for this criteria: 1.7 X 2 = **3.4**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

   This project's score for this criteria: 1.75 X 2 = **3.5**

6. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

   This project's score for this criteria: 3 X 2 = 6

Total Valuation Score for this project: **3.9**

126686802.2.3	*PROJECT OPTION* *2.5.1*	*PROJECT COMPONENT(S)* *2.5.1 (A-D)*	**UT Southwestern Ambulatory Practice: Redesigning for cost containment**	
The University of Texas Southwestern Medical Center				TPI **126686802**
Related Category 3 Outcome Measure(s):	***OD-5***	**IT-5.1**	***Improved Cost Savings***	
Year 2 (10/1/2012 – 9/30/2013)	**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]: Purchase and implement a Faculty Practice based cost accounting software. Develop/identify a cost-accounting methodology to quantify the financial impact of quality and efficiency improvement interventions. **Metric 1.1** [P-1.1]: Cost-accounting methodology/metric. Baseline/Goal: Documentation of the methodology/metric Data Source: Cost-accounting system or another administrative, financial or clinical data set. **Milestone 1 Estimated Incentive Payment:** $1,691,084	**Milestone 2** [P-5]: Train Finance staff on costing methodologies and define, develop, and document methodologies with departments for allocation of costs to specific services. **Metric 2.1** [P-5.1]: Staff trainings and department specific methodologies. Baseline/Goal: Submission of trainings and department documents. Data Source: Training materials, meeting minutes, cost-accounting system or another administrative, financial or clinical data set. **Milestone 2 Estimated Incentive Payment:** $619,006 **Milestone 3** [P-3]: Implement the cost-accounting methodology and related systems to measure intervention impacts. **Metric 3.**1 [P-3.1]: Cost-accounting system. Baseline/Goal: Documentation of adoption, installation, upgrade and/or interface of technology, and/or implementation of system using existing technology.		**Milestone 5** [P-4]: Conduct cost analysis. **Metric 5.1 [P-4.1]:** Conduct analysis plan of results. Baseline/Goal: Submission of cost analysis results Data source: program plan and cost analysis report. **Milestone 5 Estimated Incentive Payment:** $993,289 **Milestone 6** [P-8]: Review project data and respond to it each month with tests of new ideas, practices, tools, or solutions. This data will be collected with simple, interim measurement systems, and will be based on self-reported data and sampling that is sufficient for the purposes of improvement. **Metric 6.1 [P-8.1**]: Number of new ideas, practices, tools, or solutions tested by UTSW. Baseline: Ideas tested in DY3 Goal: 3 new ideas, practices, tools, or solutions tested by UTSW. Data Source: Brief description of the	**Milestone 7** [I-7]: Measure cost containment by re-measuring healthcare costs of an intervention and compare to baseline to gauge improvements in cost. **Metric 7.1** [I-7.1]: Documentation of per-episode costs, measuring variations in clinical practice for similar diagnoses. Baseline: DY4 costs. Goal: Identify cost savings of different interventions for 5 clinical practices. Data Source: New Cost Accounting System Reports for selected episodes of care. **Milestone 7 Estimated Incentive Payment:** $959,699 **Milestone 8** [P-8]: Review project data and respond to it each month with tests of new ideas, practices, tools, or solutions. This data will be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the

126686802.2.3	*PROJECT OPTION* *2.5.1*	*PROJECT COMPONENT(S)* *2.5.1 (A-D)*	**UT Southwestern Ambulatory Practice: Redesigning for cost containment**	
The University of Texas Southwestern Medical Center				TPI **126686802**
Related Category 3 Outcome Measure(s):	***OD-5***	**IT-5.1**	***Improved Cost Savings***	
Year 2 (10/1/2012 – 9/30/2013)	**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: Cost-accounting system **Milestone 3 Estimated Incentive Payment:** $619,006 **Milestone 4** [P-8]: Review project data and respond to it each month with tests of new ideas, practices, tools, or solutions. This data will be collected with simple, interim measurement systems, and will be based on self-reported data and sampling that is sufficient for the purposes of improvement. **Metric [P-4.1]:** Number of new ideas, practices, tools, or solutions tested. Baseline: Zero (0). Goal: 3 new ideas, practices, tools, or solutions tested by UTSW. Data Source: Brief description of the idea, practice, tool, or solution tested each month. Could be summarized at quarterly intervals. **Milestone 4 Estimated Incentive Payment:** $619,007		idea, practice, tool, or solution tested each month. Could be summarized at quarterly intervals. **Milestone 6 Estimated Incentive Payment:** $993,289	purposes of improvement. **Metric 8.1** [P-5.1]: Number of new ideas, practices, tools, or solutions tested. Baseline: DY4 Goal: 3 new ideas, practices, tools, or solutions tested by UTSW in addition to what was tested in DY4. Data Source: Brief description of the idea, practice, tool, or solution tested each month. Could be summarized at quarterly intervals. **Milestone 8 Estimated Incentive Payment:** $959,700

126686802.2.3	***PROJECT OPTION*** ***2.5.1***	***PROJECT COMPONENT(S)*** ***2.5.1 (A-D)***	**UT Southwestern Ambulatory Practice: Redesigning for cost containment**	
The University of Texas Southwestern Medical Center				TPI **126686802**
Related Category 3 Outcome Measure(s):	***OD-5***	**IT-5.1**	***Improved Cost Savings***	
Year 2 (10/1/2012 – 9/30/2013)		**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: $1,691,084		Year 3 Estimated Milestone Bundle Amount: $1,857,019	Year 4 Estimated Milestone Bundle Amount: $1,986,578	Year 5 Estimated Milestone Bundle Amount: $1,919,399
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $7,454,080				

Project Option 2.9.1 – Implement/Expand Care Coordination Programs

RHP Project Identification Number: 126686802.2.4
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center/TPI 126686802

Summary Information

Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds 452-beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, UTSW physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices.

Intervention(s):. This project will establish a health care navigation program in the UTSCAP Network comprised of care coordinators that provide support to patient populations who are most at risk of receiving disconnected and fragmented care.

Need for the Project: As we build the UTSCAP Network and actively recruit community-based primary care physicians and their practices into the Network, we must be to target those patients who are moderate to high risk patients, ensuring that these patients receive coordinated, timely and site-appropriate services. This is necessary to reduce our Region's high emergency department utilization and readmission rates.

Target Population: The target population is our UTSCAP Network patients (our patients) identified during DY2 as needing care coordination management services. Approximately 3% of our patients are either Mediciad eligible or indigent, so we expect at least 3% of our targeted patients receiving care coordination services to be Medicaid eligible or indigent patients.

Category 1 or 2 Expected Patient Benefits: In 2012, UT Southwestern Hospital – St. Paul had a total of 34,293 ER cases, of those cases 40% where provided to Medicaid/Charity/low income patients. Patients admitted through the ER had a substantially higher readmit rate than non-ER patients. In addtion, the percent of low income patients actually needing hospitalization was disproportionately low to all other patients who sought care in the ER. To benefit these and all RHP 9 patients, UTSW intends to implement a roubust care coordination program. By monitoring patient care gaps and intervening on a timely basis before they seek facility care, UTSW expects to have a significant impact to RHP 9 patients. UTSW anticipates adding 126 primary care physicians to the Network. UTSW expects that by DY5 approximately 277,000 patients, including 44,000 Medicaid/low income patients, could benefit from this care coordination project each year. This program will generate a substantially amount of care coorindator patient contacts that will occur outside a typical care setting. We anticipate 1,100,000 overall and 177,000 Medicaid/low income primary care patient contacts per year in

DY5. Over the course of this project we expect this enhanced care coordination will reduce unnecessary utilization and redirect care that would otherwise be provided in higher cost settings.

The project seeks to increase the increase the number of new patients referred for services from the navigator program that are seen in a primary care setting and empanelled to a medical home by 10% in DY 5.

Category 3 Outcome Measures:

- IT-1.10 Diabetes Care: HgbA1C.

- IT-3.1 All cause 30 day readmission rate

Project Description

UT Southwestern proposes to establish a health care navigation program in the UTSCAP Network comprised of care coordinators that provide support to patient populations who are most at risk of receiving disconnected and fragmented care.

This Health Care Navigation Program will be implemented in the UTSCAP Network. The UTSCAP Primary Care Network (the "Network") is designed to integrate community-based primary care physicians and the faculty physicians of UT Southwestern Medical Center ("UT Southwestern"). The Network is in an early stage of development and growth and is actively recruiting community-based primary care physicians and their practices to join UT Southwestern faculty physicians. The ultimate goal of the Network is delivering patient care at the highest level of quality by the most cost-effective means, achieved through the clinical integration of Network physicians. Such outcomes are good for patients, payors, physicians and the community. The specific short and long-term objectives for the Network include:

- Expanding, strengthening and implementing a clinically integrated network;
- Developing an infrastructure for effective care coordination of Network patients;
- Enhancing and continually developing a clinically integrated organizational structure in preparation of health care reform and value-based reimbursement; and
- Advancing the use of technology to improve health care and reduce medical errors.

The care coordination program will consist of a teams of individuals. The program goals and scope of activities will be set by a physician medical director. The teams will interact directly within the program parameters with each primary care physician office. Each team will be lead by a nurse such as a RN or LVN with clinical experience in direct patient care. Additional members of the care coordination program will include medical assistants, social worker, clerical staff and community health workers. Each team will be assigned to help a number of primary care physician offices in geographic proximity. The nurse leading each team will meet regularly with the primary care physician and/or his office staff to ensure that the care coordination efforts are not being duplicated by the office staff and that the efforts are meshing well together and meeting the needs of network patients and the primary care physicians.

The care coordinator program from this Health Care Navigation Program will target Network patients who are moderate to high risk patients, ensuring that these patients receive coordinated, timely and site-appropriate health care services. The moderate and high risk patients will be identified by a variety of mechanisms. Some will be identified by the primary care physicians office as patients known to have high risk diseases, medical care compliance problems, or social barriers to care compliance. Other high risk patients will be identified by analysis of electronic health record data and payor claims data. The care coordinator program will assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations. In

addition, UT Southwestern will provide necessary training for all members of the care coordinator team so that these these team members will be able to guide patients in a culturally sensitive and linguistically appropriate manner through the Network. The goal of this Health Care Navigation Program is to address both chronic care management and the critical transition care components of a population management program focused on moderate to high risk Network patients.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationships to Regional Goals

The goal of this project is to utilize care coordinator teams as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient navigators will help and support these patients to navigate through the continuum of health care services.

- Create a Health Care Navigation Program of high quality, efficient, and cost effective care coordination resources;
- Identify and manage intensive and high-risk patients in close coordination with primary care offices;
- Use information technology resources to collect utilization and quality data on care coordinator assigned patient panels; and
- Leverage and extend physicians and other providers through the use of care coordinators that use data and expertise to assure patients are engaged the most cost effective, high quality care delivered to patients in the right place, at the right time, by the right provider.

A major goal of the region is to reduce the unnecessary utilization in the Emergency Departments and reduce unnecessary readmission rates. This project will contribute to that goal by providing patient navigation resources that would identify patients that are eligible to receive care in a more appropriate setting.

Challenges

Historically, patients at UT Southwestern have been managed through appointment and follow-up medicine initiated by a material health event or complaint. Referral patterns would likely apply and the PCP would effectively turn over control of the patient periodically, sometimes to return and other times not. The patient would move as directed by the physician in charge at

the time and important integration and efficiency mechanisms would not be apply. In addition payors would not incentivize a centralization of responsibility or coordination of care.

UT Southwestern plans to overcome these challenges by complimenting the ACO/PCMH infrastructure of the UTSCAP Network with coordinate care activities to minimize duplicated services, provide steady assistance to Network patients throughout the care continuum, and eventual return the patient to their primary care physician. The care coordinators will directly connect with physicians and patients to ensure all parties are informed of and engaged in the patient's care plan and opportunities to avoid negative impacts to the patient's health status, including ED visits and relapse/readmission. This care coordination process will also focus on removing some of the unnecessary cost variability in patient care.

5-Year expected outcomes for providers and patients

The 5-year expected outcome for UT Southwestern and its Network is improved patient engagement through a "PCP hub" as well as improved cost and quality outcomes relative to the traditional model. Patients will be actively supported by a broader array of healthcare professionals and have a better understanding of their care plan. In 2012, UT Southwestern Hospital – St. Paul had a total of 34,293 ER cases, of those cases 40% where provided to Medicaid/Charity/low income patients. Patients admitted through the ER had a substantially higher readmit rate than non-ER patients. In addtion, the percent of low income patients actually needing hospitalization was disproportionately low to all other patients who sought care in the ER. To benefit these and all RHP 9 patients, UTSW intends to implement a roubust care coordination program. By monitoring patient care gaps and intervening on a timely basis before they seek facility care, UTSW expects to have a significant impact to RHP 9 patients. UTSW anticipates adding 126 primary care physicians to the Network. UTSW expects that by DY5 approximately 277,000 patients, including 44,000 Medicaid/low income patients, could benefit from this care coordination project each year. This program will generate a substantially amount of care coordinator patient contacts that will occur outside a typical care setting. We anticipate 1,100,000 overall and 177,000 Medicaid/low income primary care patient contacts per year in DY5. Over the course of this project we expect this enhanced care coordination will reduce unnecessary utilization and redirect care that would otherwise be provided in higher cost settings. The expected outcomes for the Patient Navigation Program are to have:

- Identified frequent ED users and use of navigators as part of preventable ED reduction program.
- Trained health care navigators in cultural competency.
- Deployed innovative health care personnel such as case managers/workers, community health workers and other types of health professionals as patient navigators.
- Connected patients to primary and preventative care.

- Increased access to care management and/or chronic care management, including education in chronic disease self-management.

- Decrease hospital readmission rates.

Starting Point/Baseline

During DY2 frequent ED users and other high risk Network patients will be identified based on a needs assessment to identify the patient population for which the program will be targeted. Patient navigation and care management will be provided to these patients. DY2 will serve as the baseline period for the project. Based on the number of patients served by the project, the number of providers trained to support the program will be identified and implemented

Rationale

UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, UT Southwestern's faculty physician practice is one of the largest providers of physician services to the Medicaid program in Texas. For example, between December 2010 and November 2011, UT Southwestern physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices. Thus, UT Southwestern physician services are directly impacted by the negative outcomes and wasted resources created by the fragmented, uncoordinated delivery of care.

Emergency Department utilization in North Texas exceeds national utilization rates resulting in higher costs for providing care to the region. The Community Health Needs Assessment points to a lack of accessing primary care sites and the inability to redirect patients to a more appropriate care setting. The patient navigator project will provide resources to help patients and their families better locate and navigate appropriate care locations.

UT Southwestern is looking to efficiently coordinate care throughout the Network and thereby, managing the many care and quality activities necessary to make meaningful progress in clinical outcomes and delivering care in the right setting at the right time. UT Southwestern will further its goal towards a highly-integrated model of care delivery by linking active care coordination capabilities to the UT Southwestern ACO/PCMH initiative. Direct interaction and engagement of all parties (care coordinators, community health workers, physicians, and patients) supports active management of health conditions and reduction in unnecessary hospital readmissions. This project is a highly effective way to help promote the continuity of care for all patients, including Medicaid patients.

Project components

Through the care coordination program, we propose to meet all the required project components.

a. *Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.*

   We will identify network patients using the emergency department for primary care services, patients without a designated PCP or medical home, and offer navigation services. Patient navigators or care coordinators will create social services notes in the EHR that will be associated with the patients' medical record by medical record number. These notes will include sections on reason for services, assessment, subsequent referrals and follow-up activities.

b. *Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.* Currently community health workers do not exist in our health care system. We propose creating and training such workers as part of our care coordination team. Candidates to be community health care workers will be individuals who live in a specific geographic region and have a good understanding of the neighborhood and the health care barriers that may be unique to that neighborhood. Candidates to be community health care workers could be students, retirees, and stay at home moms or dads. These workers would probably best work on a part time basis and would be trained by the nurse team leader or medical assistants to help with specific targeted areas of concern, medical management, or health care goal.

c. *Connect patients to primary and preventive care,*

   We will have regular contact with Network primary care physicians for care management services, preventive care, and other educational and social services. Network primary care physicians are automatically "enrolled" in the care coordination program. Network patients identified as benefiting from care coordination will be contacted with an introduction to our services. Care coordinators will be available to meet with providers to answer any specific questions. Due to our healthcare system's relative lack of primary care physicians, the care management program will be an important bridge until the patient can get established with a new primary care physician. The program can help expedite the establishment of a physician patient relationship with the primary care physician based upon medical priority. The nurses team leader can also assist in arranging age appropriate medical care that would fall within the scope of a nurse's abilities acting under standing orders established by the care coordination program medical director while patients are awaiting initial appointments with their new primary care physician.

d. *Increase access to care management and/or chronic care management, including education in chronic disease self-management, and*

e. *Conduct quality improvement for project using methods such as rapid cycle improvement.*

We will design a reporting template for the care coordinator notes that will include standardized fields where possible. We will create a data registry for enrolled patients to facilitate follow-up and effectiveness analysis. Reports will be run regularly and shared with ED staff and participating primary care providers. In addition, the UT Southwestern Quality Assurance Committee will review this data at its regular meetings and review for opportunities for program improvement and expansion.

Reasons/rationale for selecting the outcome measures

We selected a standalone measure from the domain of potentially preventable re-admission rates, because this is one of the clinical outcomes measures where we believe the impact of our project will be measureable and with improvement in the measure resulting in improved lives of our patients and reducing unnecessary health care costs. In addition, we selected a standalone measure to access the control of diabetes in our patients. 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. RHP 9 has similar opportunity to benefit from improvements in identifying and managing patients with this condition. While our goal of this project is to utilize a care coordinator program as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients, we selected diabetes care as our outcome measure because of the prevalence of diabetes in our region.

We subscribe to the theory that if you don't measure things you can't manage them. UT Southwestern will be focusing on these outcomes for all our attributed patients, irrespective of their socioeconomic status. As a result, we believe focusing on these outcomes will make a measurable difference for individuals in RHP 9 at all income levels.

Specify the unique community need identification number the project addresses:

- CN.2- Regional Healthcare Infrastructure and Patient Migration Patterns
- CN.3-Healthcare Capacity
- CN.8-Specialty Care
- CN.9-Chronic Disease
- CN.11-Patient Safety and Quality
- CN13- Emergency Department Usage and Readmissions

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

This project is a new initiative because the UTSCAP Network does not provide patient navigation services for Network patients.

Related Category 3 Outcome Measures:

OD-1 Primary Care and Chronic Disease Management:

- IT-1.110 Diabetes care: HbA1c poor control (>9.0%)

OD-3 Potentially preventable Re-Admissions- 30 day Readmission Rates

- IT-3.1 All cause 30 day readmission rate

Relationship to other Projects

The success of this initiative is highly dependent on the implementation of a number of other initiatives within UTSW contributions to the RHP9 plan. Likewise, developing this foundation will be critical to the success of most of the other projects included in the UTSW RHP program. This project is tightly linked to the following RHP projects:

- ***126686802.1.2—Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics:***

- ***126686802.2.1—Expanding the Medical Home Model in the UTSCAP Primary Care Network:***

- ***126686802.1.3—Implement a Quality Incentive Program for Network Primary Care Providers:***

- ***126686802.1.4—Implement UT Southwestern Population Management Infrastructure: UTSCAP Pri***mary Care Network clinics will provide services to Network patients via a Network-wide population management infrastructure to improve quality and efficiency in the care they deliver.

    - ***126686802.2.5—Expanding Care Transition Programs: The development, implementation and e***valuation under standardized protocols and evidence-based care delivery model through a network of post-acute care providers to improve the care delivered to people during transitions ***o***f care will rely heavily on robust population management infrastructure.

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

Plan for Learning Collaborative: The Anchor plans to develop and facilitate Learning Collaboratives in the Region with DFW Hospital Council. UT Southwestern will participate in the Collaborative(s) as appropriate. Collaboration will be particularly important as the region seeks

to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the criteria listed below as being most significant to differentiate between projects. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

This project's score for this criteria: 4 X 2 = **8**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

This project's score for this criteria: 4 X 2 = **8**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 4.3 X 2 = **8.6**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 3 X 2 = **6**

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 3.5 X 2 = **7**

Total Valuation Score for this project: **7.7**

126686802.2.4	*2.9.1*	*2.9.1 (A-E)*	*IMPLEMENT/EXPAND CARE COORDINATION PROGRAMS*	
UT Southwestern Medical Center Faculty Practice Plan				*TPI 126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.25* *126686802.3.26*	*IT-1.10* *IT-3.1*	*Diabetes care: HbA1c poor control (>9.0%)* *All cause 30 day readmission rate*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. Metric 1 [P-1.1]: Provide report identifying target population, etc. Baseline: No baseline assessments of targeted population. Goal: Report identifying needs of target population. Data Source: Program documentation, registry, CDR, EHR, claims, needs assessment report. **Milestone 1 Estimated Incentive Payment: $1,067,351** **Milestone 2** [P-2]: Establish 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. Baseline: Zero (0) number of Network care coordinators during the baseline period. Goal: Hire 1 care coordinator.	**Milestone 4** [P-2]: Establish a health care navigation program to provide support to patients 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. Baseline: 1 care coordinator. Goal: Hire 2 care coordinators above baseline. Data Source: HR records. **Milestone 4 Estimated Incentive Payment: $703,250** **Milestone 5** [P-2]: Establish 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-2.3]: Frequency of contact with care navigators for high risk patients.	**Milestone 9** [P-2]: Establish a health care navigation program to provide support to patients 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. Baseline: 3 care coordinator. Goal: Hire 2 care coordinators above baseline. Data Source: HR records. **Milestone 9 Estimated Incentive Payment: $470,196** **Milestone 10** [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements. Metric 1 [I-8.1]: Participate in semi-annual face-to-face meetings or seminars organized	**Milestone 17** [P-2]: Establish a health care navigation program to provide support to patients 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. Baseline: 5 care coordinator. Goal: Hire 1 care coordinators above baseline. Data Source: HR records. **Milestone 17 Estimated Incentive Payment: $454,296** **Milestone 18** [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements. Metric 1 [I-8.1]: Participate in semi-annual face-to-face meetings or seminars organized

126686802.2.4	*2.9.1*	*2.9.1 (A-E)*	*IMPLEMENT/EXPAND CARE COORDINATION PROGRAMS*	
UT Southwestern Medical Center Faculty Practice Plan				*TPI 126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.25* *126686802.3.26*	*IT-1.10* *IT-3.1*	*Diabetes care: HbA1c poor control (>9.0%)* *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)**
Data Source: Patient navigation program materials, HR records, database, and EHR. **Milestone 2 Estimated Incentive Payment: $1,067,351** **Milestone 3** [P-4]: Increase patient engagement, such as through patient education, selfmanagement support, improved patient-provider communication techniques, and/or coordination with community resources. Metric 1 [P-4.1]: Number of classes and/or initiations offered, or number or percent of patients enrolled in the program. Baseline: Zero (0) patients enrolled in program during baseline period. Goal: 300 patients registered. Data Source: Registry, CDR, or EHR report/analysis. **Milestone 3 Estimated Incentive Payment: $1,067,350**	Baseline: 300 patients registered in program. Goal: 3 contacts with each high risk patients annually. Data Source: Registry, CDR, or EHR report/analysis. **Milestone 5 Estimated Incentive Payment: $703,250** **Milestone 6** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.1]: Increase medical home empanelment of patients referred from navigator program. Baseline: Zero (0) medical home patient empanelment. Goal: 100 empaneled patients. Data Source: Registry, CDR, or EHR report/analysis. **Milestone 6 Estimated Incentive Payment: $703,250** **Milestone 7** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. Metric 1 [I-10.1]: Increase percentage	by the RHP. Baseline: Zero (0) number of face-face meetings. Goal: 2 meetings Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 10 Estimated Incentive Payment: $470,196** **Milestone 11** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services Metric 1 [I-6.1]: Increase medical home empanelment of patients referred from navigator program Baseline: 100 empaneled patients. Goal: 100 empaneled patients above baseline.. Data Source: Registry, CDR, or EHR report/analysis. **Milestone 11 Estimated Incentive Payment: $470,196** **Milestone 12** [I-6]: Increase number of	by the RHP. Baseline: 2 face-face meetings. Goal: 2 meetings Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 18 Estimated Incentive Payment: $454,296** **Milestone 19** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services Metric 1 [I-6.1]: Increase medical home empanelment of patients referred from navigator program Baseline: 200 empaneled patients. Goal: 100 empaneled patients above baseline.. Data Source: Registry, CDR, or EHR report/analysis. **Milestone 19 Estimated Incentive Payment: $454,296** **Milestone 20** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent

126686802.2.4	*2.9.1*	*2.9.1 (A-E)*	*IMPLEMENT/EXPAND CARE COORDINATION PROGRAMS*	
UT Southwestern Medical Center Faculty Practice Plan				*TPI 126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.25* *126686802.3.26*	*IT-1.10* *IT-3.1*	*Diabetes care: HbA1c poor control (>9.0%)* *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)**
	of target population reached. Baseline: % population reached in DY2. Goal: 5% increase over baseline. Data Source: Registry, CDR, or EHR report/analysis. **Milestone 7 Estimated Incentive Payment: $703,249** **Milestone 8** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. Metric 1 [I-10.2]: Increased number of primary care referrals. Baseline: Number of primary care referrals in DY2. Goal: 5% increase over baseline. Data Source: Registry, CDR, or EHR report/analysis. **Milestone 8 Estimated Incentive Payment: $703,249**		PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services Metric 1 [I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Baseline: ED patients receiving PCP education in DY3. Goal: 5% increase over baseline. Data Source: Registry, CDR, or EHR report/analysis. **Milestone 12 Estimated Incentive Payment: $470,196** **Milestone 13** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services Metric 1 [I-6.5]: Number/percent of patients with a primary care provider who are given a scheduled primary care provider appointment Baseline: patients with a primary care provider who are given a scheduled primary care provider appointment in DY3.	care, and/or hospital services Metric 1 [I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Baseline: ED patients receiving PCP education in DY4. Goal: 5% increase over baseline. Data Source: Registry, CDR, or EHR report/analysis. **Milestone 20 Estimated Incentive Payment: $454,296** **Milestone 21** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services Metric 1 [I-6.5]: Number/percent of patients with a primary care provider who are given a scheduled primary care provider appointment Baseline: patients with a primary care provider who are given a scheduled primary care provider appointment in DY4. Goal: 5% increase over baseline. Data Source: Registry, CDR, or EHR

126686802.2.4	*2.9.1*	*2.9.1 (A-E)*	*IMPLEMENT/EXPAND CARE COORDINATION PROGRAMS*	
UT Southwestern Medical Center Faculty Practice Plan				*TPI 126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.25* *126686802.3.26*	*IT-1.10* *IT-3.1*	*Diabetes care: HbA1c poor control (>9.0%)* *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)**
			Goal: 5% increase over baseline. Data Source: Registry, CDR, or EHR report/analysis. **Milestone 13 Estimated Incentive Payment: $470,196** **Milestone 14** [I-7]: Reduce number of ED visits and/or avoidable hospitalizations for patients enrolled in the navigator program Metric 1 [I-7.1]: ED visits and/or avoidable hospitalizations. Baseline: Zero (0) avoidable ER/hospitalizations. Goal: 10 avoidable ER visits/hospitalizations. Data Source: EHR, navigation program database, ED records, inpatient records. **Milestone 14 Estimated Incentive Payment: $470,196** **Milestone 15** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. Metric 1 [I-10.1]: Increase percentage of target population reached. Baseline: % population reached in	report/analysis. **Milestone 21 Estimated Incentive Payment: $454,295** **Milestone 22** [I-7]: Reduce number of ED visits and/or avoidable hospitalizations for patients enrolled in the navigator program Metric 1 [I-7.1]: ED visits and/or avoidable hospitalizations. Baseline: 10 avoidable ER visits/hospitalizations. Goal: 10 avoidable ER visits/hospitalizations above baseline. Data Source: EHR, navigation program database, ED records, inpatient records. **Milestone 22 Estimated Incentive Payment: $454,295** **Milestone 23** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. Metric 1 [I-10.1]: Increase percentage of target population reached. Baseline: % population reached in DY4.

126686802.2.4	*2.9.1*	*2.9.1 (A-E)*	*IMPLEMENT/EXPAND CARE COORDINATION PROGRAMS*	
UT Southwestern Medical Center Faculty Practice Plan				*TPI 126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.25* *126686802.3.26*	*IT-1.10* *IT-3.1*	*Diabetes care: HbA1c poor control (>9.0%)* *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)**
			DY3. Goal: 5% increase over baseline Data Source: Registry, CDR, or EHR report/analysis. **Milestone 15 Estimated Incentive Payment: $470,196** **Milestone 16** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. Metric 1 [I-10.2]: Increased number of primary care referrals. Baseline: Number of primary care referrals in DY2. Goal: 5% increase over baseline. Data Source: Registry, CDR, or EHR report/analysis. **Milestone 16 Estimated Incentive Payment: $470,196**	Goal: 5% increase over baseline Data Source: Registry, CDR, or EHR report/analysis. **Milestone 23 Estimated Incentive Payment: $454,295** **Milestone 24** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. Metric 1 [I-10.2]: Increased number of primary care referrals. Baseline: Number of primary care referrals in DY2. Goal: 5% increase over baseline. Data Source: Registry, CDR, or EHR report/analysis. **Milestone 24 Estimated Incentive Payment: $454,296**
Year 2 Estimated Milestone Bundle Amount: **$3,202,052**	Year 3 Estimated Milestone Bundle Amount: **$3,516,248**		Year 4 Estimated Milestone Bundle Amount: **$3,761,568**	Year 5 Estimated Milestone Bundle Amount: **$3,634,365**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***: $14,114,233**				

Project Option 2.12.1 – Implement/Expand Care Transition Programs

RHP Project Identification Number: 126686802.2.5
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center Faculty Practice Plan/TPI 126686802

Summary Information

Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds 452-beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, UTSW physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices.

Intervention(s): This project will develop, implement and evaluate standardized protocols and evidence-based care delivery model through a network of post-acute care providers and community organizations to improve care delivered to people during transitions of care.

Need for the Project: The UTSCAP Network does not have a patient stratification system or care transitions protocols to ensure the efficient transition of care for our patients, resulting in diminished efficiency and quality of care.

Target Population: The target population is our UTSCAP Network patients (our patients) requiring transitions in care. Approximately 3% of our patients are either Mediciad eligible or indigent, so we expect at least 3% patients requiring transitions in care to be Medicaid eligible or indigent patients benefiting from this care.

Category 1 or 2 Expected Patient Benefits: The project seeks to (1) create a patient identification system using a validated risk assessment tool, (2) implement a case management related registry, (3) increase the number of care tranistions protocols by 5% in DY3, (4) increase the number of patients in the case management related registry by 5% in DY4, and (5) increase the number of times patients in our target population receive standardized care according to the approved clinical protocols and care transitions policies by 5% in DY5.

In 2012, UT Southwestern Hospital – St. Paul had a total of 34,293 ER cases, of those cases 40% where provided to Medicaid/Charity/low income patients. Patients admitted through the ER had a substantially higher readmit rate than non-ER patients. In addtion, the percent of low income patients actually needing hospitalization was disproportionately low to all other patients who sought care in the ER. To benefit these and all RHP 9 patients, UTSW intends to implement a roubust care transition program. By carefully managing transitions amongst providers and settings, UTSW expects to have a significant impact to RHP 9 patients. UTSW expects that by DY5 approximately 277,000 patients, including 44,000 Medicaid/low income

patients, could be covered under this care transition program each year. This program will generate a substantial amount of transition care planning. Over the course of this project we expect this enhanced care transition activity will reduce unnecessary utilization and redirect care that would otherwise be provided in higher cost settings.

Category 3 Outcome Measures:

- IT-1.10 Diabetes Care: HgbA1C, IT-3.1 All cause 30 day readmission rate

Project Description

UT Southwestern proposes to develop, implement and evaluate standardized protocols and evidence-based care delivery model through a network of post-acute care providers and community organizations to improve care delivered to people during transitions of care.

Through this project, UT Southwestern will develop criteria and protocols around various discharge conditions, while identifying post-acute providers who can and will adhere to evidence-based practices. UT Southwestern will also identify "at risk" patients through data and risk stratification methodologies, engage PCPs, expand non-physician practitioner access, and introduce Care Coordinators to ensure proper post-discharge follow-up care in order to support improvement of baseline quality, cost, and other metrics. UT Southwestern will develop and implement post-discharge care management protocols targeted toward patients who are at higher risk for readmission, and ensure that patients receive post-discharge outreach according to the established protocols. The outreach protocol should at a minimum include discussion of the patient's symptoms/disease process, medication review, inquiry regarding living environment, and confirmation of clinician appointments.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals

The stated goal of our project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Ensuring hospital discharges are accomplished appropriately and that care transitions occur effectively and safely will be important to meeting the objectives of RHP9 patient populations. Care transitions refer to the movement of patients from one health care provider or setting to another. Transitions from hospital to home or nursing home have been shown to be problematic and costly. Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. The lack of coordination that exists today has led to avoidable hospital readmission.

UT Southwestern's goal will be to develop care coordination teams, information resources, a network of high quality, efficient, and cost effective post-acute providers and community organizations in order to coordinate these care transitions with providers outside UT Southwestern's own delivery system so that post-acute patients will receive optimal care. UT Southwestern plans to work with existing nationally-recognized performance standards as well as develop proprietary standards to conduct engaged follow-up care by post-acute providers along with UT Southwestern's Faculty and affiliated physicians.

A major goal of the region is to improve the delivery of coordinated care and reduce likelihood of readmissions. This project would contribute to achieving that goal by developing care coordination teams, information resources, developing and implementing post-discharge care management protocols targeted toward patients who are at higher risk for readmission, and ensure that patients receive post-discharge outreach according to the established protocols. In addition, emergency department utilization is high in RHP 9 and by providing more patients with the coordinated care they need, when they need it, this project helps achieve the regional goal to keep patients from unnecessarily using the emergency departments and urgent care centers as a means to receive basic care.

Challenges

Historically, at all health care systems, including UT Southwestern, patients have been discharged from the acute inpatient setting without understanding all the care that was actually provided during the admission and what risks required continued management following discharge. Patients discharged back into the community without a pre-scheduled follow-up appointment and uncertain of how to care for themselves or what complications to look for, suffer an increase risk of relapse and readmission. In addition to creating unnecessary patient confusion and suffering, providers have not coordinated these transitions effectively amongst themselves.

Another challenge associated with inefficient care transitions is the resulting economic costs. Although post-acute care spending in RHP 9 is substantially higher than the national average, we aren't seeing the expected outcomes, i.e. improved health, from those investments. We must develop strategies to improve care transition programs while limiting spending growth to the health system overall. UT Southwestern's ownership of home health services provides an opportunity to substantially improve patient and/or caretaker understanding of treatment regimen and illness prevention education, while allowing the patient to return to a familiar setting for post-acute medical care sooner.

5-Year expected outcome for Provider and Patients

The 5-year expected outcome for UT Southwestern is primary care physician engagement, improved post-discharge processes and protocols, increased utilization of care coordinators and high quality/ highly educated non-physician practitioners, enhanced interpretation services, culturally educated providers, and coordinated care management. RHP 9 patients will enter the new primary care physician/patient-centric care continuum seamlessly and with highly engaged, quality providers. With timely post-discharge follow-up, problems with the patient's understanding and identification of possible complications can be quickly identified and addressed. Improved metrics will reflect the efforts through reduced cost, readmission rates, and improved quality outcomes. Finally, identifying and working with high quality network of post-acute providers that are committed to providing evidence based care will improve quality and cost efficiency.

Between December 2010 and November 2011, UTSW physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices. In 2012, UT Southwestern Hospital – St. Paul had a total of 34,293 ER cases, of those cases 40% where provided to Medicaid/Charity/low income patients. Patients admitted through the ER had a substantially higher readmit rate than non-ER patients. In addtion, the percent of low income patients actually needing hospitalization was disproportionately low to all other patients who sought care in the ER. To benefit these and all RHP 9 patients, UTSW intends to implement a roubust care transition program. By carefully managing transitions amongst providers and settings, UTSW expects to have a significant impact to RHP 9 patients. UTSW expects that by DY5 approximately 277,000 patients, including 44,000 Medicaid/low income patients, could be covered under this care transition program each year. This program will generate a substantial amount of transition care planning. Over the course of this project we expect this enhanced care transition activity will reduce unnecessary utilization and redirect care that would otherwise be provided in higher cost settings.

Patients will be actively supported by a broader array of healthcare professionals and processes to increase connections and checkpoints to confirm and stabilize and potentially improve their recovery. This program should improve the patient's understanding of care delivered, minimize unnecessary stress, and strengthen their role in recovery, creating a shared ownership of an improved health outlook. That engagement could also improve connections to lower cost channels and reduce ED intake.

Starting Point/Baseline

UT Southwestern has a robust electronic medical record system in both its inpatient and outpatient facilities. However, UT Southwestern via the UTSCAP Network has not developed and implemented a patient stratification system or care transition protocols. Thus, the starting point for this initiative, prior to December 1, 2011, is zero (0).

Rationale

UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, UT Southwestern's faculty physician practice is one of the largest providers of physician services to the Medicaid program in Texas. For example, between December 2010 and November 2011, UT Southwestern physicians provided care to Charity and Medicaid patients during 274,498 visits, of which 16,175 visits were specifically at UT Southwestern outpatient practices. Thus, UT Southwestern physician services are directly impacted by the negative outcomes created by inadequate transitions of care for the patients of RHP 9.

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. Additionally, poorly

designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Patient transition is a multidimensional concept and may include transfer from the hospital to home, or nursing home, or from facility to home and community-based services, etc.

Development of a seamless transition from an inpatient environment to an outpatient setting, possibly with the use of home health or palliative care services, or if appropriate a strategically selected alternative institutional setting, such as a high quality and cost effective LTAC or SNF is important for optimizing quality and efficiency. In addition to implementing primary care physician-centric information and care management models, we must ensure adequate metrics are identified and implemented to document and improve results for all constituencies, resulting in a decrease of readmissions and costly medical interventions.

Project components

To accomplish UT Southwestern's ultimate goal of implementing improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings, UT Southwestern's project includes the following core elements:

a. Review best practices from a range of models (e.g. RED, BOOST, STAAR, INTERACT, Coleman, Naylor, GRACE, BRIDGE, etc.),

b. Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR) tool) and patient Interviews,

c. Integrate information systems so that continuity of care for patients is enabled,

d. Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days,

e. Implement discharge planning program and post discharge support program,

f. Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers,

g. Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

To progress towards this objective, UT Southwestern has selected a number of milestones and metrics that are relevant to the community needs and priorities of RHP 9. These milestones and metrics are more fully described in the table below.

Unique community need identification number the project addresses:

- CN.3-Healthcare Capacity
- CN.8-Specialty Care
- CN.9-Chronic Disease
- CN.11-Patient Safety and Quality
- CN.12-Emergency Department Usage and Readmissions

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

As described herein, the current environment in RHP 9 and UT Southwestern for these important care transitions is not optimally coordinated. UT Southwestern still must rely on the manual transmission of data when transferring care outside of UT Southwestern. This has lead to less than optimal quality results, higher ER utilization, patient dissatisfaction, and avoidable readmissions. By materially enhancing the coordination of these transitions amongst providers and the tools to accomplish this coordination, the UTSCAP Network will be able to address the issue of uncoordinated transitions of care within our region.

Related Category 3 Outcome Measures:

OD-1 Primary Care and Chronic Disease Management:

- IT-1.10 Diabetes care: HbA1c poor control (>9.0%)

OD-3 Potentially preventable Re-Admissions- 30 day Readmission Rates

- IT-3.1 All cause 30 day readmission rate

With post-acute care spending in RHP 9 being substantially higher than the national average, we selected a standalone measure from the domain of potentially preventable re-admission rates. This is where we believe the impact of our project will be measureable. In addition, we selected a standalone measure to access the control of diabetes in our patients. 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. RHP 9 has similar opportunity to benefit from improvements in identifying and managing patients with this condition. While UT Southwestern's ultimate goal is implementing improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings, UT Southwestern's selected diabetes care as our outcome measure because of the prevalence of diabetes in our region.

We subscribe to the theory that if you don't measure things you can't manage them. UT Southwestern will focus on these outcomes for all our attributed patients, irrespective of their socioeconomic status. As a result, we believe focusing on these outcomes will make a measurable difference for individuals in RHP 9 at all income levels.

Relationship to other Projects

The success of this initiative is highly dependent on the implementation of a number of other initiatives within UT Southwestern contributions to the RHP9 plan. Likewise, developing this foundation will be critical to the success of most of the other projects included in the UT Southwestern RHP program. This project is tightly linked to the following RHP projects: 2.1.1, 1.1.2, 1.4.2, 1.10.2, 1.7.1, 2.11.2, and 2.9.1.

- ***126686802.1.2—Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics:*** This project improves access to primary care services by creating a robust Network of efficient, quality primary care physicians for RHP 9 patients.

- ***126686802.1.3—Implement a Quality Incentive Program for Network Primary Care Providers:*** UTSCAP Primary Care Network clinics will be able to participate in a quality incentive program. However, their ability to participate in this quality incentive program will be dependent upon their enrollment and participation in the Medicaid program, creating an environment whereby primary care physicians see all populations as a viable part of a broader patient population management program.

- ***126686802.1.4—Implement UT Southwestern Population Management Infrastructure Development:*** UTSCAP Primary Care Network clinics will provide services to Network patients via a Network-wide population management infrastructure to improve quality and efficiency in the care they deliver.

- ***126686802.2.5—Implement/Expand Care Coordination Programs:*** UTSCAP Primary Care Network clinics will provide services to Network patients via access to the

Network's care coordinators, ensuring that all Network patients receive coordinated, timely, and site-appropriate health care services.

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

The Anchor plans to develop and facilitate Learning Collaboratives in the Region with DFW Hospital Council. UT Southwestern will participate in the Collaborative(s) as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the criteria listed below as being most significant to differentiate between projects. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criteria: 5 X 2 = **10**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population. This project's score for this criteria: 4.5 X 2 = **9**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues. This project's score for this criteria: 4.75 X 2 = **9.5**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person. This project's score for this criteria: 4.5 X 2 = **9**

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.This project's score for this criteria: 4.5 X 2 = **9**

Total Valuation Score for this project: **9.4**

126686802.2.5	*2.12.1*	*2.12.1 (a-g)*	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS*	
UT Southwestern Medical Center Faculty Practice Plan				*TPI 126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.27* *126686802.3.28*	*IT-1.10* *IT-3.1*	*Diabetes care: HbA1c poor control (>9.0%)* *All cause 30 day readmission rate*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-7]: Develop a staffing and implementation plan Metric 1 [P-7.1]: Documentation of the staffing plan Baseline: No plan available during baseline period. Goal: Documented staffing plan Data Source: Staffing and implementation plan **Milestone 1 Estimated Incentive Payment: $1,300,833** **Milestone 2** [P-8]: Improve discharge summary timeliness. Metric 1 [P-8.1]: Improve percent discharge summary completion within 48 hours of discharge. Baseline: Unknown discharge summary completion rate.. Goal: Establish a baseline for discharge summaries completed within 48 hours. Data Source: Report from Health Information Services or other. **Milestone 2 Estimated Incentive**	**Milestone 4** [P-5]: Using a validated risk assessment tool, create a patient identification system. Metric 1 [P-5.1]: Patient stratification system Baseline: No risk stratification system available. Goal: Implementation of risk stratification system. Data Source: Documentation of stratification system implementation. **Milestone 4 Estimated Incentive Payment: $612,204** **Milestone 5** [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 instructions Metric 1 [P-1.1]: Care transitions protocols Baseline: Zero (0) care transition protocols (Find out from Betty Chambers how many we have). Goal: Add 5 care transition protocols Data Source: Submission of protocols,		**Milestone 11** [P-12]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements. Metric 1 [I-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline: Zero (0) meetings. Goal: 2 meetings. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 11 Estimated Incentive Payment: $916,882** **Milestone 12** [I-10]: Identify the top chronic conditions and other patient characteristics or socioeconomic factors that are common causes of avoidable readmissions.	**Milestone 16** [P-12]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements. Metric 1 [I-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline: 2 meetings. Goal: 2 meetings in DY5. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 16 Estimated Incentive Payment: $885,877** **Milestone 17** [I-10]: Identify the top chronic conditions and other patient characteristics or socioeconomic factors that are common causes of avoidable readmissions.

126686802.2.5	*2.12.1*	*2.12.1 (a-g)*	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS*	
UT Southwestern Medical Center Faculty Practice Plan				*TPI 126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.27* *126686802.3.28*	*IT-1.10* *IT-3.1*	*Diabetes care: HbA1c poor control (>9.0%)* *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)**
Payment: $1,300,833 **Milestone 3** [P-9]: Implement a case management related registry. Metric 1 [P-9.1]: Documentation of registry implementation. Baseline: No registry. Goal: Implement registry. Data Source: Documentation of registry implementation. **Milestone 3 Estimated Incentive Payment: $1,300,834**	Care transitions program materials **Milestone 5 Estimated Incentive Payment: $612,204** **Milestone 6** [P-8]: Improve discharge summary timeliness. Metric 1 [P-9.1]: Improve percent discharge summary completion within 48 hours of discharge. Baseline: DY2 established number Goal: 10% improvement Data Source: Report from Health Information Services or other. **Milestone 6 Estimated Incentive Payment: $612,204** **Milestone7** [I-10]: Identify the top chronic conditions and other patient characteristics or socioeconomic factors that are common causes of avoidable readmissions. Metric 1 [I-10.1]: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in		Metric 1 [I-10.1]: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-admissions. Baseline: 10 physicians. Goal: Deliver report to top 25 physcians. Data Source: Registry or EHR report/analysis. **Milestone 12 Estimated Incentive Payment: $916,882** **Milestone 13** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Baseline: DY 3 establish baseline of paitents receiving evidence based care per protocol. Goal: 5% improvement over baseline.	Metric 1 [I-10.1]: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-admissions. Baseline: 25. Goal: Deliver report to top 40 physcians. Data Source: Registry or EHR report/analysis. **Milestone 17 Estimated Incentive Payment: $885,877** **Milestone 18** [I-11]: Improve the percentage of patients in defined populations receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Baseline: DY 4 establish baseline of paitents receiving evidence based care per protocol. Goal: 5% improvement over baseline.

126686802.2.5	*2.12.1*	*2.12.1 (a-g)*	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS*
UT Southwestern Medical Center Faculty Practice Plan			*TPI 126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.27* *126686802.3.28*	*IT-1.10* *IT-3.1*	*Diabetes care: HbA1c poor control (>9.0%)* *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)
	highest rates of re-admissions. Baseline: No established report. Goal: Develop report identifying patients of focus and deliver to top 10 physicians. Data Source: Registry or EHR report/analysis. **Milestone 7 Estimated Incentive Payment: $612,204** **Milestone 8** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies. Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines. Baseline: Establish baseline of paitents of patients receiving evidence based care per protocol in DY 2. Goal: 5% improvement over baseline. Data Source: Registry or EHR report/analysis	Data Source: Registry or EHR report/analysis **Milestone 13 Estimated Incentive Payment: $916,882** **Milestone 14** [I-13]: Increase the number of patients in the case management related registry. Metric 1 [I-13.1]: Increase in the number of patients in the case management related registry; patients may be targeted from ED and inpatient areas. Baseline: Patients in registry in DY3. Goal: 5% increase over baseline. Data Source: EHR, claims, registry or other program documents **Milestone 14 Estimated Incentive Payment: $916,882** **Milestone 15** [I-14]: Implement standard care transition processes in specified patient populations. Metric 1 [I-14.1]: Measure adherence to processes. Baseline: Establish baseline	Data Source: Registry or EHR report/analysis **Milestone 18 Estimated Incentive Payment: $885,877** **Milestone 19** [I-13]: Increase the number of patients in the case management related registry. Metric 1 [I-13.1]: Increase in the number of patients in the case management related registry; patients may be targeted from ED and inpatient areas. Baseline: Patients in registry in DY4. Goal: 5% increase over baseline. Data Source: EHR, claims, registry or other program documents **Milestone 19 Estimated Incentive Payment: $885,876** **Milestone 20** [I-14]: Implement standard care transition processes in specified patient populations. Metric 1 [I-14.1]: Measure adherence to processes. Baseline: Establish baseline

126686802.2.5	*2.12.1*	*2.12.1 (a-g)*	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS*	
UT Southwestern Medical Center Faculty Practice Plan				*TPI 126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.27* *126686802.3.28*	*IT-1.10* *IT-3.1*	*Diabetes care: HbA1c poor control (>9.0%)* *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 8 Estimated Incentive Payment: $612,204 **Milestone 9** [I-13]: Increase the number or percent of patients in the case management related registry . Metric 1 [I-13.1]: Increase in the number or percentage of patients in the case management related registry; patients may be targeted from ED and inpatient areas. Baseline: Patients in registry in DY2. Goal: 5% increase over baseline. Data Source: EHR, claims, registry or other program documents **Milestone 9 Estimated Incentive Payment: $612,204** **Milestone 10** [I-14]: Implement standard care transition processes in specified patient populations. Metric 1 [I-14.1]: Measure adherence to processes. Baseline: Establish baseline measure of process adherence in DY2. Goal: 5% improvement to process adherence.		measure of process adherence in DY3. Goal: 5% improvement to process adherence.Data Source: EHR, claims, registry or other program documents **Milestone 15 Estimated Incentive Payment: $916,883**	measure of process adherence in DY4. Goal: 5% improvement to process adherence.Data Source: EHR, claims, registry or other program documents **Milestone 20 Estimated Incentive Payment: $885,876**

126686802.2.5	*2.12.1*	*2.12.1 (a-g)*	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS*	
UT Southwestern Medical Center Faculty Practice Plan				*TPI 126686802*
Related Category 3 Outcome Measure(s):	*126686802.3.27* *126686802.3.28*	*IT-1.10* *IT-3.1*	*Diabetes care: HbA1c poor control (>9.0%)* *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)**
	Data Source: EHR, claims, registry or other program documents **Milestone 10 Estimated Incentive Payment: $612,204**			
Year 2 Estimated Milestone Bundle Amount: **$3,902,500**	Year 3 Estimated Milestone Bundle Amount: **$4,285,428**		Year 4 Estimated Milestone Bundle Amount: **$4,584,411**	Year 5 Estimated Milestone Bundle Amount: **$4,429,383**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***: $17,201,722**				

Project Option 2.11.2: Conduct Medication Management

RHP Project Identification Number: 126686802.2.6
Performing Provider Name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW") Faculty Practice Plan/ TPI 126686802

Summary Information:
Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, 24% of UTSW patient charges were attributed to Medicaid patients across Parkland, Children's and UT Southwestern.

Intervention(s): This project will implement an enhanced patient medication management program that should lead to improved health outcomes for UT Southwestern patients of RHP 9.

Need for the Project: An untold number of readmissions and other healthcare resource consumption can be linked to poor medication management. Our Region has a high rate of readmissions and ED usage. As an academic medical center, UT Southwestern is routinely the referral destination for many of the RHP 9's most complex patients. Complex patients are more likely to have a larger number of medications, which can increase the odds of higher hospital readmission rates. UT Southwestern believes improvements in medication management will lead to improved quality and reduce unnecessary utilization.

Target Population: The target population is all patients seen by UT Southwestern. At this point it's difficult to precisely predict the impact of this initiative on various segments of our target population, but we expect the benefits of the Medication Management project to impact Medicaid and/or indigent patients proportionally to their percentage of the target population.

Category 1 or 2 Expected Patient Benefits: We expect improved PCP prescribing practices (particularly for physician outliers), which would represent more consistent and outcome-based prescribing actions. We also expect benefits associated with patients being more engaged in their own care as well as being able to avoid the inconvenience of unnecessary readmissions, ED visits, and doctor visits. UTSW intends to implement a robust medication management program. By carefully managing patient medications, UTSW expects to have a significant impact to RHP 9 patients. UTSW expects that by DY5 approximately 277,000 patients, including 44,000 Medicaid/low income patients, could be impacted by this medication program each year. This program will generate a substantial amount of medication management. Over the course of this project, we expect this enhanced medication management activity will reduce unnecessary utilization and cost that would otherwise be born by the system.

Category 3 Outcome Measures: IT-3.12 Other - readmission rate - medications readmissions

Project Description:

UT Southwestern proposes to implement an enhanced patient medication management program that should lead to improved health outcomes for patients of RHP 9.

Using analytic tools leveraging EMR, claims, and other data, staff will identify patients at high risk for developing complications and co-morbidities. Related patient information in the EMR will be used to review the complete medication regimen. Patients will then receive counseling and education about the medications, and an action plan will be developed that includes patient education, goal setting and potential adjustments in the medication regimen. Patient response will then be monitored and adjustments made accordingly. Analytic tools will be used to alert staff when patients have not refilled their medications according to the protocol. Root cause analysis will be used to identify potential medication errors and quality improvement processes will be used to address the causes.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals:

Develop a capability to conduct Medication Management for the population to tightly manage patient pharmaceuticals and avoid adverse events associated with medical misuse. The project goals are as follows:

- Develop patient medication tracking for all prescriptions inside and outside health system
- Conduct evaluations of the particular risks based on medication, dosage, counter-indications, co-morbidities, and episodic factors
- Address instructive measures for patients and providers knowing medication alternatives and responsibilities associated with the regimen
- Assist patients in compliance in the regimen with lists, pill cases, and reminders through various means flexible to the patient's preferred technology and media

Establish linkages to other parts of integration, including vital monitoring, telemedicine, and others that enhance the patient experience and outcomes.

This project also meets the following regional goals:

A major goal of the region is to provide improved access to coordinated primary and specialty care. This project would contribute to achieving that goal by establishing systems to improve medication management. An untold number of readmissions and other healthcare resource consumption can be linked to poor medication management. Attempting to increase the

utilization of generic drug use when appropriate also reduces cost, which is also a regional issue.

Challenges:
Historically, medications have been managed depending on the personal expertise and communication style of the physician. In addition, patients have had various levels of interest in education and optimization based on the trust of that provider. Overcoming the challenges of moving from a 1:1 approach to something global and comprehensive in nature will require multiple flexible solutions to meet provider and patient needs. This will help improve all parties understanding of options, patient engagement opportunities, and expected outcomes.

UTSW would overcome these challenges by leveraging technology to assess the information and efficiently deliver information to providers and patients to support an optimized regimen. Key relationships would be developed to extend technology and support distributing information flexibly.

5-Year Expected Outcome for Provider and Patients:
The 5-year expected outcome for Providers is improved PCP prescribing practices (particularly for outliers), which would represent more consistent and outcome-based prescribing actions. We also expect benefits associated with patients being more engaged in their own care as well as being able to avoid the inconvenience of unnecessary readmissions, ED visits, and doctor visits.

UTSW physicians provided care to Charity and Medicaid patients during 16,175 visits which were specifically at UT Southwestern outpatient practices. UTSW intends to implement a robust medication management program. By carefully managing patient medications, UTSW expects to have a significant impact to RHP 9 patients. UTSW expects that by DY5 approximately 277,000 patients, including 44,000 Medicaid/low income patients, could be impacted by this medication program each year. This program will generate a substantial amount of medication management. Over the course of this project, we expect this enhanced medication management activity will reduce unnecessary utilization and cost that would otherwise be born by the system.

Starting Point/Baseline:
Region patients currently experience little organized support in this very important aspect of maintaining health under maintenance medications. Understanding their medications and options is limited to what information was provided potentially some time ago. Identifying related cohorts and assessing risks and opportunities will help to avoid adverse events.

Key baseline statistics would be patients under Medication Management as well as establishing the ability to track individual issues that can educate a provider or improve patient outcomes (e.g., mis-prescribed antibiotics). UTSW will initiate this project in DY2.

Rationale:
More than 3.5 billion prescriptions are written annually in the United States (Sommers JP. Prescription drug expenditures in the10 largest states for persons under age 65, 2005.2008. Agency for Healthcare Research and Quality. Available at: http://meps.ahrq.gov/mepsweb/data_files/publications /st196/stat196.pdf. Accessed 10/11/12). Medications are involved in 80 percent of all treatments and impact every aspect of a patient's life. According to the World Health Organization, adherence to therapy for chronic diseases in developed countries averages 50%, and the major consequences of poor adherence to therapies are poor health outcomes and increased health care costs (WHO. 2003. Adherence to long-term therapies: Evidence for action. Available at: http://whqlibdoc.who.int/ publications/2003/9241545992.pdf. Accessed 10/11/12). Drug-related morbidity and mortality costs exceed $200 billion annually in the U.S., exceeding the amount spent on the medications themselves (Johnson J, Bootman JL. Drug-related morbidity and mortality. Arch Intern Med. 1995; 155(18):1949-1956; Johnson JA, Bootman JL. Drug-related morbidity and mortality. Am J Health Syst Pharm. 1997; 54(5):554-558; Ernst, FR, Grizzle AJ. Drug related morbidity and mortality: Updating the cost-of-illness model. J Am Pharm Assoc. 2001; 41(2):192-199)).

Patients with chronic diseases and multiple chronic conditions are likely to be on multiple medications for long periods of time thereby increasing the risk of medication errors. Considering the high rates of chronic diseases in our region, this projects would potentially lead to improved outcomes and cost savings for the health system.

Project Components:

Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors. This project option could include one or more of the following components:

a) Develop criteria and identify targeted patient populations; e.g. chronic disease patient populations that are at high risk for developing complications, co-morbidities, and/or utilizing acute and emergency care services.
b) Develop tools to provide education and support to those patients at highest risk of an adverse drug event or medication error.
c) Conduct root cause analysis of potential medication errors or adverse drug events and develop/implement processes to address those causes
d) Conduct quality improvement for project using methods such as rapid cycle improvement.

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

Community Needs Addressed:
As indicated in the RHP 9 Community Needs Assessment, the demand for primary and specialty care services exceeds that of available medical physicians, thus limiting access to healthcare

services for chronic disease management or preventive services. The specific and unique community need identification numbers that this project addresses include the following:

- CN.4-Primary Care and Pediatrics
- CN.8- Chronic Disease Management
- CN.11-Patient Safety and Quality
- CN.12-ED Usage and Readmissions

Related Category 3 Outcome Measure(s):

IT-3.12 Other - readmission rate - complications of medications readmissions

Reasons/rationale for selecting the outcome measures:
The relationship between hospital readmission rates and quality of care is well-documented. Some readmissions are caused from medication complications from the index admissions or from circumstances surrounding the initial hospital stay. Patients who take a large number of medications in particular have high hospital readmission rates and high rates are considered by some as an indication of weakness in the overall care of patients with a particular condition. Only readmissions to the same facility will be included as part of each hospital's rates.

Relationship to other Projects:
Medication management is an important component of our planned delivery system reform and is related to other planned UT Southwestern DSRIP projects. This is an important component to reaching our patient population right where they have needs related to their medications in a low-cost setting while ensuring high quality, evidence-based care is delivered. The success of this initiative is highly dependent on the implementation of the following other projects proposed by UT Southwestern:

- ***126686802.1.1.2—Expanding Existing Primary Care Capacity in the UTSCAP Network: Via UT Southwestern Ambulatory Clinics and Affiliated, Community Primary Care Clinics:*** This project improves access to primary care services by creating a robust Network of efficient, quality primary care physicians for RHP 9 patients. As community-based primary care physicians join the Network, they will no longer be practicing in "isolation". Through clinical integration with UT Southwestern faculty physicians, these community-based primary care physicians will engage in the continual development and implementation of clinical "best practice" protocols for the diseases treated by all Network physicians that are also responsible for the largest percentage of medical costs.

- ***126686802.1.1.4—Implement a Quality Incentive Program for Network Primary Care Providers:*** UTSCAP Primary Care Network clinics will be able to participate in a quality incentive program. However, their ability to participate in this quality incentive program will be dependent upon their enrollment and participation in the Medicaid program, creating an environment whereby primary care physicians see all populations as a viable part of a broader patient population management program.

- ***126686802.1.10.2—Implement UT Southwestern Population Management Infrastructure Development:*** UTSCAP Primary Care Network clinics will provide services to Network patients via a Network-wide population management infrastructure to improve quality and efficiency in the care they deliver.

- ***126686802.2.9.1—Implement/Expand Care Coordination Programs:*** UTSCAP Primary Care Network clinics will provide services to Network patients via access to the Network's care coordinators, ensuring that all Network patients receive coordinated, timely, and site-appropriate health care services.

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

Plan for Learning Collaborative:
The Anchor plans to develop and facilitate Learning Collaboratives in the Region with DFW Hospital Council. UT Southwestern will participate in the Collaborative(s) as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation:
The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

This project's score for this criteria: 2.5 X 2 = **5**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

This project's score for this criteria: 2.5 X 2 = **5**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 2.5 X 2 = **5**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 3.175 X 2 = **6.35**

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 3 X 2 = **6**

Total Valuation Score for this project: **5.10**

These values are provided for in the table below and are allocated equally amongst the milestones.

126686802.2.6	*PROJECT OPTION* 2.11.2	*PROJECT COMPONENT(S)* 2.11.2 (A-C)	*CONDUCT MEDICATION MANAGEMENT*	
The University of Texas Southwestern Medical Center Faculty Practice				126686802
Related Category 3 Outcome Measure(s): **IT-3.12 Other - readmission rate**		***IT-3.12***	*[Outcome Measure (Improvement Target) Title(s)]* **IT-3.12 Other - readmission rate - complications of medications 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)**
Milestone 1 [P-1.]: Implement /expand a medication management program and/or system Metric 1.1 [P-1.1]: Program elements. Baseline: No existing program. Goal: Documentation of program, including people, processes and technologies. Data Source: Written medication management plan including workflow. **Milestone 1 Estimated Incentive Payment: $733,914** **Milestone 2** [P-2.]: Develop criteria and identify targeted patient populations Metric 2.1 [P-2.1.]: Establish evidence based criteria for medication management planning in target population based on assessment of population needs Baseline: No established evidence based criteria. Goal: Documentation of evidence based criteria for target population.		**Milestone 4** [P-6.]: Develop health information technology claims-based algorithms to identify patients in need of medication reconciliation, management or education. Such algorithms typically search historical claims for the physician billing for the most recent claims with an evaluation and management (E&M) code or pharmacy claim, or the largest share of E&M visits for the patient177. Claims-based approaches are expeditious because the insurer avoids the costs of collecting information from patients and physicians. Metric 6.1 [P-6.1]: Documented HIT claims-based algorithms to identify patients in need of medication reconciliation, management or education. Baseline:No claims based algorithms or system. Goal: Implement a claims based algorithm process and/or system. Data Source: Registry, CDR, EMR, contract or other evidence of	**Milestone 9** [I-8.]: Identify patients with chronic disease who receive medication management in their discharge instructions appropriate for their chronic disease. Metric 9.1 [I-8.1]: Patients with chronic disease who receive appropriate disease specific medication management. Baseline: Number of patients with a chronic medical condition who receive medication management instruction at discharge in DY3 Goal: 2% increase in percentage of patients receiving instructions Data Source: Registyr, CDR, EMR, or other reporting sources. **Milestone 9 Estimated Incentive Payment: $431,078** **Milestone 10** [I-9.]: Manage medications for targeted patients Metric 10.1 [I-9.1]: Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication	**Milestone 15** [I-8.]: Identify patients with chronic disease who receive medication management in their discharge instructions appropriate for their chronic disease. Metric 15.1 [I-8.1]: Patients with chronic disease who receive appropriate disease specific medication management. Baseline: Number of patients with a chronic medical condition who receive medication management instruction at discharge in DY4. Goal: 2% increase in percentage of patients receiving instructions Data Source: Registyr, CDR, EMR, or other reporting sources. **Milestone 15 Estimated Incentive Payment: $416,500** **Milestone 16** [I-9.]: Manage medications for targeted patients Metric 16.1 [I-9.1]: Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication

126686802.2.6	*PROJECT OPTION* 2.11.2	*PROJECT COMPONENT(S)* 2.11.2 (A-C)	*CONDUCT MEDICATION MANAGEMENT*	
The University of Texas Southwestern Medical Center Faculty Practice				126686802
Related Category 3 Outcome Measure(s): **IT-3.12 Other - readmission rate**		***IT-3.12***	*[Outcome Measure (Improvement Target) Title(s)]* **IT-3.12 Other - readmission rate - complications of medications 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)**
Data Source: Written criterion for target population and program participation. **Milestone 2 Estimated Incentive Payment: $733,914** **Milestone 3** [P-2.]: Develop criteria and identify targeted patient populations Metric 3.1 [P-2.2.]: Written medication management plan(s) Baseline: # of Patients with written medication management plan during baseline period (DY1). Goal: 5% increase in number of patients with a written medication management plan. Data Source: Paper or electronic medical record, registry, CDR, or other information citing medication management counseling provided; medication reconciliation documented in paper or electronic medical record **Milestone 3 Estimated Incentive Payment: $733,913**		implementation. **Milestone 4 Estimated Incentive Payment: $483,557** **Milestone 5** [P-7.]: Implement Computerized Provider Order Entry (CPOE) to allow providers to enter medical orders directly via computer, replacing the more traditional paper, verbal, telephone, and fax methods. Metric 5.1 [P-7.1]: create a system to implement CPOE Baseline: No documented plan or system Goal: Develop a plan to expand the use of CPOE Data Source: Documentation of plan **Milestone 5 Estimated Incentive Payment: $483,557** **Milestone 6** [I-8.]: Identify patients with chronic disease who receive medication management in their discharge instructions appropriate for their chronic disease.	management. Baseline: Number of patients that consistently receive medication management counseling in DY3. Goal: Increase percentage over baseline by 5%. Data Source: Registyr, CDR, EMR, or other reporting sources. **Milestone 10 Estimated Incentive Payment: $431,078** **Milestone 11** [I-18.]: CPOE utilization measure Metric 11.1 [I-18.1]: Increase the number of computerized provider order entries Baseline: Number of entry orders within Network in DY3 Goal: 5% increase in percentage over baseline. Data Source: Registyr, CDR, EMR, or other reporting sources. **Milestone 11 Estimated Incentive Payment: $431,078**	management. Baseline: Number of patients that consistently receive medication management counseling in DY4. Goal: Increase percentage over baseline by 3%. Data Source: Registyr, CDR, EMR, or other reporting sources. **Milestone 16 Estimated Incentive Payment: $416,500** **Milestone 17** [I-18.]: CPOE utilization measure Metric 17.1 [I-18.1]: Increase the number of computerized provider order entries Baseline: Number of entry orders within Network in DY3 Goal: 10% increase in percentage over baseline. Data Source: Registyr, CDR, EMR, or other reporting sources. **Milestone 17 Estimated Incentive Payment: $416,500**

126686802.2.6	*PROJECT OPTION* 2.11.2	*PROJECT COMPONENT(S)* 2.11.2 (A-C)	*CONDUCT MEDICATION MANAGEMENT*	
The University of Texas Southwestern Medical Center Faculty Practice				126686802
Related Category 3 Outcome Measure(s): **IT-3.12 Other - readmission rate**		***IT-3.12***	*[Outcome Measure (Improvement Target) Title(s)]* **IT-3.12 Other - readmission rate - complications of medications 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)**
	Metric 6.1 [I-8.1]: Patients with chronic disease who receive appropriate disease specific medication management. Baseline: Number of patients with a chronic medical condition who receive medication management instruction at discharge in DY2. Goal: 2% increase Data Source: Registyr, CDR, EMR, or other reporting sources. **Milestone 6 Estimated Incentive Payment: $483,557** **Milestone 7** [I-9.]: Manage medications for targeted patients Metric 7.1 [I-9.1]: Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management. Baseline: Number of patients that consistently receive medication management counseling in DY2 Goal: Increase over baseline by 10%. Data Source: Registyr, CDR, EMR, or other reporting sources.		**Milestone 12** [I-11.]: Increase the number of patients receiving medication management from acute care to the ambulatory setting Metric 12 [P-11.1.]: Percent of discharged patients who received medication reconciliation as part of the transition from acute to ambulatory care Baseline: Number of discharged patients who received medication reconciliation in DY3. Goal: 2% increase Data Source: Registyr, CDR, EMR, or other reporting sources. **Milestone 12 Estimated Incentive Payment: $431,078** **Milestone 13** [I-12]: Implement electronic prescription writing at the point of care. Metric 13 [I-12.1.]: Increase the number of new and refill prescriptions written and generated electronically. Baseline: Number of new and refill prescriptions written and	**Milestone 18** [I-11.]: Increase the number of patients receiving medication management from acute care to the ambulatory setting Metric 18 [P-11.1.]: Percent of discharged patients who received medication reconciliation as part of the transition from acute to ambulatory care Baseline: Number of discharged patients who received medication reconciliation in DY4. Goal: 2% increase in percentage over baseline. Data Source: Registyr, CDR, EMR, or other reporting sources. **Milestone 18 Estimated Incentive Payment: $416,500** **Milestone 19** [I-12]: Implement electronic prescription writing at the point of care. Metric 19 [I-12.1.]: Increase the number of new and refill prescriptions written and generated electronically. Baseline: Number of new and refill

126686802.2.6	*PROJECT OPTION* 2.11.2	*PROJECT COMPONENT(S)* 2.11.2 (A-C)	*CONDUCT MEDICATION MANAGEMENT*	
The University of Texas Southwestern Medical Center Faculty Practice				126686802
Related Category 3 Outcome Measure(s): **IT-3.12 Other - readmission rate**		***IT-3.12***	*[Outcome Measure (Improvement Target) Title(s)]* **IT-3.12 Other - readmission rate - complications of medications 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)**
	Milestone 7 Estimated Incentive Payment: $483,557 **Milestone 8** [I-18.]: CPOE utilization measure Metric 7.1 [I-18.1]: Increase the number of computerized provider order entries Baseline: Number of entry orders within Network in DY2 Goal: 10% increase over baseline. Data Source: Registyr, CDR, EMR, or other reporting sources. **Milestone 8 Estimated Incentive Payment: $483,556**		generated electronically in DY3. Goal: 2% increase in percentage over baseline Data Source: Registyr, CDR, EMR, or other reporting sources. **Milestone 13 Estimated Incentive Payment: $431,077** **Milestone 14** [I-16]: Improvement in selected clinical measures in target population Metric 14 [I-16.1]: TBD by Performing Provider Percent of patients who have shown improvement in selected clinical measures in targeted patient population Baseline: Number of patients that have shown improvement (as defined by their provider) in a selected clinical measure compared to their baseline measures over a defined period of time (i.e. DY3). Goal: 2% increase in percentage over baseline Data Source: Registyr, CDR, EMR, or other reporting sources.	prescriptions written and generated electronically in DY4. Goal: 2% increase Data Source: Registyr, CDR, EMR, or other reporting sources. **Milestone 19 Estimated Incentive Payment: $416,500** **Milestone 20** [I-16]: Improvement in selected clinical measures in target population Metric 20 [I-16.1]: TBD by Performing Provider Percent of patients who have shown improvement in selected clinical measures in targeted patient population Baseline: Number of patients that have shown improvement (as defined by their provider) in a selected clinical measure compared to their baseline measures over a defined period of time (i.e.DY4). Goal: 3% increase in percentage over baseline Data Source: Registyr, CDR, EMR, or other reporting sources.

126686802.2.6	*PROJECT OPTION* *2.11.2*	*PROJECT COMPONENT(S)* *2.11.2 (A-C)*	*CONDUCT MEDICATION MANAGEMENT*	
The University of Texas Southwestern Medical Center Faculty Practice				126686802
Related Category 3 Outcome Measure(s): **IT-3.12 Other - readmission rate**		***IT-3.12***	*[Outcome Measure (Improvement Target) Title(s)]* **IT-3.12 Other - readmission rate - complications of medications 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)**
			Milestone 14 Estimated Incentive Payment: $431,077	**Milestone 20 Estimated Incentive Payment: $416,501**
Year 2 Estimated Milestone Bundle Amount: $ 2,201,741		Year 3 Estimated Milestone Bundle Amount: $ 2,417,784	Year 4 Estimated Milestone Bundle Amount: $ 2,586,466	Year 5 Estimated Milestone Bundle Amount: $ 2,499,001
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5): $* 9,704,992				

Project Option: 2.9.1
Title of Project: Implementation of an emergency department patient navigation system

Unique Project ID: 175287501.2.1 (Pass 2)
Performing Provider Name/TPI: The University of Texas Southwestern University Hospitals/ TPI 175287501

Project Summary

Provider: The University of Texas Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds 452-beds in the St. Paul and Zale Lipshy buildings and 40 hospital-based and ambulatory-based clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. UT Southwestern physicians provide a majority of the physician services within RHP 9 safety-net hospitals, specifically Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. For example, between December 2010 and November 2011, an average of 24% of UTSW patient visits were attributed to Medicaid patients across Parkland, Children's and UT Southwestern.

Intervention(s): This project will establish an emergency department navigator system for patients without a known primary care physician. At first this project will cover 5 days per week but expand hours according to target population needs.

Need for the project: Currently, 30% of patients seen in our ED do not have a documented Primary Care Physician (PCP) for follow up/urgent care and primary care (using third quarter UTSW 2012 data).

Target population: The target population will be all patients presenting at the UTSW University Hospitals ED without a documented primary care physician. Our hospital attributes 11% of its days serving Medicaid (i.e. based on weighted patient days), while our faculty clinical practice population is comprised of approximately 3% Medicaid and indigent patients. Thus, we expect at least 11% of the navigator services to benefit Medicaid and/or indigent patients. The most recent data we have regarding the number of Medicaid and charity patients seen in our ED shows 12,663 cases in FY12.

Category 1 or 2 expected patient benefits: This project is expected to reduce potentially preventable hospitalizations for ambulatory care sensitive conditions. We project that 25% of patients without a primary care physician will receive a referral during DY4 and 50% will receive such a referral during DY5. By end of project, 5,250 patients per year will receive referral to a primary care physician from our ED including 1000 Medicaid patients who do not have an identified primary care physician.

Category 3 outcomes:

- IT-2.12 Prevention Quality Indicators (PQI) Composite Measure Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions.

Project Description:

This project will utilize project option 2.9.1. Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care. The project will implement a patient navigator system in the UT Southwestern University Hospitals Emergency Department (ED) to assist patients with special needs and patients without a primary care provider in connecting with the necessary provider. The goal will be to decrease the number of patients seen in the ED who do not have a primary care physician identified in the UT Southwestern electronic record.

Many patients are seen in the ED who do not have an identified primary care physician and consequently receive inadequate follow up for ED visits and inadequate primary preventive care. The 5 year outcome for this project will be to reduce the percent of patients seen in our ED who do not have an identified primary care physician in our electronic health record (EHR). Currently, the ED at UT Southwestern University hospitals sees 33-35,000 visits per year. Of these patients, 30% do not have an identified Primary Care Physician (PCP) using third quarter 2012 data. The target population will be the 9,900 – 10,500 patients seen in the Emergency Department without a primary care physician. We estimate that 1080 – 1150 of these patients will have Medicaid or be indigent based on the above numbers and percentages. The cost avoidance realized in this project will be measured by reduced preventable admissions. During the baseline determination, the project will determine the number of preventable admissions then reduce those admissions by 5% during DY4 and DY5 each. According to the RHP 9 Needs Assessment, each of the avoided admissions will save Medicaid patients $47,500. The most recent data we have regarding the number of Medicaid and charity patients seen in our ED can be seen in this table.

Payor Group	Total Charge	Cases	ENR
Medicaid Total	**$6,687,830**	**4,375**	**$1,145,553**
	11.3%	15.9%	5.0%
Self Pay	**$12,673,790**	**8,288**	**$6,780,261**
	21.5%	30.0%	29.6%
Total Medicaid/Charity/Self Pay	**$19,361,620**	**12,663**	**$7,925,814**
	32.8%	45.9%	34.6%

During the baseline determination, the project will determine the number of preventable admissions then reduce those admissions by 5% during DY4 and DY5 each. Since the average

cost of a Medicaid admission costs $47,000 we predict that the approximately 100 admissions that would be prevented in Medicaid patients will result in about $4.7M saved by cost avoidance.

Collaboration

This project is one of two projects being proposed through a collaboration agreement. The specific collaboration arrangement specific to this project is set forth below.

Collaborators	DY2	DY3	DY4	DY5	Total
Parkland Memorial Hospital	751,352	1,325,241	1,447,902	1,617,111	5,141,606
Project / Collaboration	**DY2**	**DY3**	**DY4**	**DY5**	**Total**
Category 2 Project Value	1,242,668	1,270,954	1,268,783	1,024,645	4,807,050
Related Category 3 Projects Value	146,196	169,461	271,925	650,255	1,237,837
Total Project Value	**1,388,864**	**1,440,415**	**1,540,708**	**1,674,900**	**6,044,887**

The collaboration involves the transfer of Pass 2 allocated dollars from Parkland Memorial Hospital (public entity) to the performing provider (public entity). The combined project value for this project exceeds the funding provided by the collaborating entity.

The collaborating parties have joined together in this collaboration with the belief that the goals of this project are valuable and will contribute to regional transformation.

Goals and Relationship to Regional Goals:

The goals of this project are aimed at reducing unnecessary ED visits and hospitalization by patients who do not have an identified primary care physician. Our goals are related to the Regional goals of reducing unnecessary ED utilization and improving the burden of chronic diseases by increasing access to primary care.

Challenges: At UTSW we are challenged with a problem of ED patients not having a primary care physician they can see for follow up or for urgent care. Consequently, these patients return for urgent care to the emergency department or have inadequate follow up for visits to the emergency department. This project will seek to decrease that problem.

5-Year Expected Outcome for Provider and Patients: Over the span of this project we plan to decrease the number of patients seen in our ED who do not have adequate follow up for chronic conditions and thereby reduce the number of potentially preventable admissions to the hospital. Over the span of this project, we estimate approximately 2000 Medicaid patients who do not have a primary care provider will be referred to such a provider.

Starting Point/Baseline:
Currently, the ED at UT Southwestern University hospitals sees 33-35,000 visits per year. Of these patients, approximately 8% are unfunded and 30% do not have an identified Primary Care Physician (PCP) using third quarter 2012 data.

Rationale:
Patients who have no primary care physician are frequently seen for episodic care in the ED. Providing these patients with a primary care option for routine and urgent care is a viable method to decrease ED utilization for non-emergencies.

The following core components will be part of this project implementation and documented as such:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
c) Connect patients to primary and preventive care.
d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
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.

Milestones

DY2 - P-1 Conduct a needs assessment to identify the patient population(s) to be targeted with the patient navigator program.
DY3 – 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.
DY4 I-6.3 Percent of patients without a primary care provider who were referred to a primary care provider in the ED
DY5 I-6.3 Percent of patients without a primary care provider who were referred to a primary care provider in the ED

Unique community need identification numbers the project addresses:

- CN.9 Chronic Disease
- CN.3 Healthcare Capacity
- CN.12 Emergency Department Usage and Readmissions

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: currently we do not have any means of directly referring patients to a specific primary care provider. This project will establish such a service.

Related Category 3 Outcome Measure(s):

One effect of poor primary care access is the need for hospitalization for conditions that can be treated as an outpatient with appropriate follow up with a primary care physician. To measure the effectiveness of this program we have chosen the following Category 3 outcome measure to see if the program is having the desired effect on unnecessary hospitalizations:

OD-2 Primary Care and Chronic Disease Management

- IT-2.12 Prevention Quality Indicators (PQI) Composite Measure Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions.
-

Reasons/rationale for selecting the outcome measure:

Hypertension is a frequent cause of ED visits and minority and low income populations are particularly vulnerable. This project, by identifying patients with hypertension who do not have a primary care provider should improve the control of blood pressure in this population.

Relationship to other Projects:

This project supports many other UTSW projects, including the following:

- 126686802.1—Establishing a New Primary Care Community Outreach Center
- 126686802.2—Expanding the Medical Home Model in the UTSCAP Primary Care Network
- 126686802.4—Implement/Expand Care Coordination Programs
- 126686802.1—Implement UT Southwestern Population Management Infrastructure Development

Plan for Learning Collaborative:

The Anchor plans to develop and facilitate Learning Collaboratives in the Region with DFW Hospital Council. UT Southwestern will participate in the Collaborative(s) as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation:

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied

towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

This project's score for this criteria: 2 X 2 = 4

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

This project's score for this criteria: 1.8 X 2 = 3.6

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 1.75 X 2 = 3.5

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 2 X 2 = 4

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 2 X 2 = 4

Total Valuation Score for this project: 8.80

175287501.2.1	***PROJECT OPTION: 2.9.1***	**Project core components: 2.9.1 (A-E)**	Implementation of an Emergency Department Patient Navigation System	
The University of Texas Southwestern University Hospitals				175287501
Related Category 3 Outcome Measure(s):	175287501.3.2	*IT 2.12*	Prevention Quality Indicators (PQI) Composite Measure Potentially Preventable Hospitalizations for Ambulatory Sensitive Conditions	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Conduct a needs assessment to identify the patient population(s) to be targeted with the patient navigator program Metric 1.1 [P-1.1]: Provide report identifying the following: a) Targeted patient population characteristics b) Gaps in services and service needs c) How program will identify, triage and manage target population d) Ideal number of patients targeted for enrollment in the patient navigation program e) Number of Patient Navigators needed to be hired f) Available site, state, county and clinical data Data Source: Program documentation, EHR, claims, needs assessment survey Rationale/Evidence: Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions Baseline/Goal: Produce Report	**Milestone 2** [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 Metric 2.1 [P-2.1] Number of people trained as patient navigators: Baseline: 0 Goal: **3** Data Source: Patient navigation program materials and database, HER **Milestone 2 Estimated Incentive Payment:** $423,651 **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 Metric 2.2 [P-2.2]: Number of unique patients enrolled in the		**Milestone 5** [I-6] Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 3.1 [I-6.3]: Percent of patients without a primary care provider who were referred to a primary care provider in the ED DY3 Baseline: 0% Goal: **25%** Data Source: HER, performing provider administrative data **Milestone 5 Estimated Incentive Payment:** $1,268,783	**Milestone 6** [I-6] Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 4.1 [I-6.3]: Percent of patients without a primary care provider who were referred to a primary care provider in the ED DY4 Baseline: 25% Goal: **50%** Data Source: HER, performing provider administrative data **Milestone 6 Estimated Incentive Payment:** $1,024,645

175287501.2.1	***PROJECT OPTION: 2.9.1***	**Project core components: 2.9.1 (A-E)**	Implementation of an Emergency Department Patient Navigation System	
The University of Texas Southwestern University Hospitals				175287501
Related Category 3 Outcome Measure(s):	175287501.3.2	*IT 2.12*	Prevention Quality Indicators (PQI) Composite Measure Potentially Preventable Hospitalizations for Ambulatory Sensitive Conditions	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
as described above. **Milestone 1 Estimated Incentive Payment:** $1,242,668	patient navigation program Baseline: 0 Goal: **30** Data Source: HER **<u>Milestone 3 Estimated Incentive Payment</u>:** $423,651 **<u>Milestone 4</u>** <u>[P-2]</u> Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care <u>Metric 2.3</u> [P-2.3]: Frequency of contact with care navigators for high risk patients <u>Baseline: 0</u> <u>Goal</u>: 1/week until placed with PCP <u>Data Source</u>: HER **Milestone 4 Estimated Incentive Payment:** $423,652			
Year 2 Estimated Milestone Bundle Amount:: **$1,242,668**	Year 3 Estimated Milestone Bundle Amount: **$1,270,954**		Year 4 Estimated Milestone Bundle Amount: **$1,268,783**	Year 5 Estimated Milestone Bundle Amount: **$1,024,645**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* **$4,807,050**				

Project Option: 2.10.1 - Implement a Palliative Care Program to address patients with end-of-life decisions and care needs
Title of Project: Expanding Palliative Care at UT Southwestern Medical Center

Unique Project ID: 175287501.2.2 (Pass 2)
Performing Provider Name/TPI: UT Southwestern University Hospital/ 175287501

Summary Information

Provider: UT Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds St. Paul and Zale Lipshy Hospitals, and 40 clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. UT Southwestern physicians provide a majority of the physician services within Parkland Memorial Hospital and Children's Medical Center at Dallas. In addition, the UTSW Faculty Practice Plan is one of the largest medical providers of physician services to Medicaid in Texas. Between December 2010 and November 2011, an average of 24% of UTSW patient visits were attributed to Medicaid patients across Parkland, Children's and UT Southwestern.

Intervention(s): This project will expand the palliative care service to provide comprehensive palliative care services to all patients of the UT Southwestern Health System.

Need for the project*:* As identified in the Community Needs Assessment for RHP 9, the lack of specialized palliative care services in our Region is a major concern. UT Southwestern seeks to address this gap in care by increasing palliative care services.

Target population: The target population will be all patients of the UT Southwestern Health System in need of palliative care services. Our hospital attributes 11% of its days serving Medicaid patients (based on weighted patient days), while our Faculty Practice population is comprised of approximately 3% Medicaid and indigent patients. It is expected that this new service will care for 900 inpatients consultations of which 100 will be Medicaid patients, and account for 3,000 outpatient visits over the span of the project of which 90 will be Medicaid patients in need of palliative care services.

Category 1 or 2 expected patient benefits: We expect that 200 new patient palliative consultations will be performed in DY3, 350 in DY4, and 500 in DY5. By DY5, 90% of patients will have chart documentation about preferences for life support options. Outpatient palliative care services will be provided for all patients identified in both the inpatient and outpatient setting. Patients will also realize improved quality of consultation through Category 3 projects.

Category 3 outcomes:

- IT-13.1 Pain assessment
- IT-13.2 Treatment Preferences

- IT-13.5 Percentage of patients with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss

Project Description:

The project utilizes project option 2.10.1 and will entail identifying patients who are in need of palliative care from the inpatient and oupatient services at UTSW. Patients identified will be those who are considered to have a high risk of dying with 6 months of identification. Patients will be screened based on meeting one or more of the following criteria: severe life-threatening illness, progressive terminal illness, significant exacerbation of chronic debilitating illness, or declining quality of life and independent functioning in the past 6 months. These patients will receive a palliative care consultation in collaboration with their primary care team. The goals of care which may include transitioning the patients from acute hospital care into home care, hospice or a skilled nursing facility. Patient/family experience surveys regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care will also be implemented.

This project will require the recruitment of physicians trained in palliative care and other team staff to expand the existing palliative care program. UTSW currently has an active palliative care program at Parkland Health and Hospital System which cannot cover the expanded need outside of Parkland. This project will exand this program to the UTSW faculty practice to fill this void.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goal and Relationship to Regional Goals:

Patients receive dignified and culturally appropriate end-of-life care, which is provided for patients with terminal illnesses in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences.

Challenges:

Need: Patients experiencing one of the conditions above need education and information about the dying process and the various options for care and help fullfilling those wishes in the existing health care environement.

Implementation: Staff recruitment and retention. The project will facillitate appropriate palliative care b providing increased numbers of providers who are trained in providing that care

5-Year Expected Outcome for Provider and Patients:

Increased uptake of palliative care services, greater involvement of patients and/or their families in end-of-life decisions, and increased satisfaction with end-of-life care. We expect at least 11% of these expanded services to benefit Medicaid and/or indigent patients. It is expected that this new service at the University Hospitals and Clinics will care for 900 new inpatients consultations of which 100 will be Medicaid patients and account for 3000 outpatient visits over the span of the project of which 90 will be Medicaid patients in need of palliative care services.

Starting Point/Baseline:

Currently, our Palliative Care Program takes care of patients at Parkland Health and Hospital System without a formal component at UT Southwestern Medical Center. Some palliative care is provided by individual services at UTSW but there is no formal program. The aim of this project will be to expand the formal program at PHHS to UT Southwestern. The baseline of services provided currently without the program at UTSW will be determined during DY3.

Rationale:

Providers provide end of life care for many more conditions than just end stage cancer. The use of palliative care in these patients can greatly improve the quality of life experienced by these patients and improve the chances of the health care system acting in accordance with patients wiishes. The goal of palliative medicine is to improve or maintain quality of life in patients with life-limiting or life-threatening diseases. Palliative medicine is a recognized medical subspecialty of both the American Board of Medical Specialties and American Osteopathic Association. Palliative medicine involves the control of symptoms associated with chronic disease such as nausea, pain and shortness of breath for example, as well as management of the symptoms that are part of the dying process.

Palliative care programs have been shown to provide cost savings while improving patients experience with dying (Archives of Internal Medicine, 2008).

Project Components:

Through the Expanding Palliative Care Project, we will meet the required project components listed below.

a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program

b) Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility

c) Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time

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

Milestones and Metrics

Process Milestones and Metrics:

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
Milestone 2 [P-5.]: Implement a palliative care program
Metric 2 [P-5.1.]: Implement comprehensive palliative care program

Improvement Milestones and Metrics:

Milestone 3 [P-6.]: Increase the number of palliative care consults
Metric 3 [P-6.1.]: Palliative care consults meet targets established by the program
Milestone 4 [I-9.]: Palliative care patients transitioned from acute hospital care into hospice. Home care, or skilled nursing facility (SNF) with and without hospice services
Metric 4 [I-9.1.]: Number of palliative care discharges to home care, hospice, or SNF/Total number of palliative care discharges
Milestone 5 [I-11.]: Establish the comfort of dying for patients with terminal illness within their
end-of-life stage of care
Metric 5 [I-11.5.]: Percentage of patients with chart documentation of preferences for life sustaining treatments.
Milestone 6 (P-6) Increase the number of palliative care consults

Unique community need identification numbers the project addresses:

- CN.12 Emergency Department Usage and Readmissions
- CN.13 Palliative Care

Related Category 3 Outcome Measure(s):

The related Category 3 outcome measures were chosen because they significantly affect the quality of life of patients who are in need of palliative care services and the satisfaction with palliative care services provided. Lack of documentation of these measures has been identified as a deficiency in the care of many palliative care patients.

OD-13 Palliative Care

- IT-13.1 Pain assessment—Increase the number of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
- IT-13.2 Treatment Preferences—Percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments.

- IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure). Increase the number of patients discharged from hospice or palliative care with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period.

Reasons/rationale for selecting the outcome measures:

The outcome measure chosen are standard measurement of the effectiveness of palliative care programs. These measures were chosen because this project involves the creation of a formal palliative care service where none currently exists.

Relationship to other Projects

175287501.2.3 Transitional Care Services for Cancer Patients
126686802.1.11 Oncology Urgent Care Services

Relationship to Other Performing Providers' Projects in the RHP:

Currently a formal Palliative Care Service is functioning at the Anchor, Parkland Health and Hospital System. This project will expand this program to include UT Southwestern Medical Center's University Hospitals and Clinics which are not currently being served by the service at the Anchor.

Plan for Learning Collaborative:

The Anchor plans to develop and facilitate Learning Collaboratives in the Region with DFW Hospital Council. UT Southwestern will participate in the Collaborative(s) as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation:

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-

point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

This project's score for this criteria: 3 X 2 = 6

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

This project's score for this criteria: 2.5 X 2 = 5

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 3.5 X 2 = 7

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 2.45 X 2 = 4.90

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 3 X 2 = 6

Total Valuation Score for this project: **5.49**

These values are provided for in the table below and are allocated equally amongst the milestones.

175287501.2.2	*PROJECT OPTION 2.10.1*	*CORE PROJECT COMPONENTS 2.10.1(A-D)*	*EXPANDING PALLIATIVE CAREPROGRAM*	
The University of Texas Southwestern University Hospitals				175287501
Related Category 3 Outcome Measure(s):	*175287501.3.3* *175287501.3.4* *175287501.3.5*	*IT-13.1* *IT-13.2* *IT-13.5*	*Pain assessment (NQF-1637) (Non-standalone measure)* *Treatment Preferences (NQF 1641) (Non-standalone measure)* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss.*	
Year 2 (10/1/2012 – 9/30/2013)	**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 1.1 [P-1.1.]: Business case Baseline: No previous business case Goal: Documentation of development of business case Data Source: Business case write-up; documentation of planning activities Rationale: New programs must go through a detailed, arduous process to justify implementation. There is a great deal of work that must be done, and support developed for a new program. **Milestone 1 Estimated incentive payment: $1,893,343**	**Milestone 2** [P-5.]: Implement a palliative care program Metric 2.1 [P-5.1.]: Implement comprehensive palliative care program Baseline/Goal: Documentation of plan implementation Data Source: Palliative care program **Milestone 2 Estimated incentive payment: $ 484,109** **Milestone 3** [P-6.]: Increase the number of palliative care consults Metric 3.1 [P-6.1.]: Palliative care consults meet targets established by the program Baseline: 0 Goal: Complete 200 palliative care consultations (Inpatient and outpatient) Data Source: EHR, palliative care database **Milestone 3 Estimated incentive payment: $ 484,109**		**Milestone 6** [P-6.]: Increase the number of palliative care consults Metric 6.1 [P-6.1.]: Palliative care consults meet targets established by the program Baseline: 0 Goal: Increase the number of palliative care consultations to 350 consultations per year (Inpatient and outpatient) Data Source: EHR, palliative care database **Milestone 6 Estimated incentive payment: $ 641,812** **Milestone 7** [I-9.]: Palliative care patients transitioned from acute hospital care into hospice, home care, or skilled nursing facility (SNF) with and without hospice services Metric 7.1 [I-9.1.]: Number of palliative care discharges to home care, hospice, or SNF/Total number of palliative care discharges Baseline: 20% Goal: 80% of eligible patients	**Milestone 9** [I-11.]: Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care Metric 9.1 [I-11.5.]: Percentage of patients with chart documentation of preferences for life sustaining treatments. Baseline: 75% Goal: 85% Data Source: EHR/Patient survey **Milestone 9 Estimated incentive payment: $ 520,386** **Milestone 10** [P-6.]: Increase the number of palliative care consults Metric 10.1 [P-6.1.]: Palliative care consults meet targets established by the program Baseline: 350 for DY4 Goal: 500 new patient consults (Inpatient and outpatient) Data Source: EHR, palliative care database **Milestone 10 Estimated incentive payment: $ 520,387**

175287501.2.2	*PROJECT OPTION 2.10.1*	*CORE PROJECT COMPONENTS 2.10.1(A-D)*	*EXPANDING PALLIATIVE CAREPROGRAM*	
The University of Texas Southwestern University Hospitals				175287501
Related Category 3 Outcome Measure(s):	*175287501.3.3* *175287501.3.4* *175287501.3.5*	*IT-13.1* *IT-13.2* *IT-13.5*	*Pain assessment (NQF-1637) (Non-standalone measure)* *Treatment Preferences (NQF 1641) (Non-standalone measure)* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss.*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 4 [I-9.]: Palliative care patients transitioned from acute hospital care into hospice, home care, or skilled nursing facility (SNF) with and without hospice services Metric 4.1 [I-9.1.]: Number of palliative care discharges to home care, hospice, or SNF/Total number of palliative care discharges Baseline: Zero, new program. Goal: 20% of eligible patients Data Source: EHR, palliative care records **Milestone 4 Estimated incentive payment: $ 484,110** **Milestone 5** [I-11.]: Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care Metric 5.1 [I-11.5.]: Percentage of patients with chart documentation of preferences for life sustaining treatments. Goal: 25% Data Source: EHR/Patient survey		Data Source: EHR, palliative care records **Milestone 7 Estimated incentive payment: $ 641,812** **Milestone 8** [I-11.]: Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care Metric 8.1 [I-11.5.]: Percentage of patients with chart documentation of preferences for life sustaining treatments. Goal: 75% Data Source: EHR/Patient survey **Milestone 8 Estimated incentive payment: $ 641,813**	**Milestone 11** [I-9.]: Palliative care patients transitioned from acute hospital care into hospice, home care, or skilled nursing facility (SNF) with and without hospice services Metric 11.1 [I-9.1.]: Number of palliative care discharges to home care, hospice, or SNF/Total number of palliative care discharges Baseline: 80% Goal: 90% Data Source: EHR, palliative care records **Milestone 11 Estimated incentive payment: $ 520,387**

175287501.2.2	*PROJECT OPTION 2.10.1*	*CORE PROJECT COMPONENTS 2.10.1(A-D)*	*EXPANDING PALLIATIVE CAREPROGRAM*	
The University of Texas Southwestern University Hospitals				175287501
Related Category 3 Outcome Measure(s):	*175287501.3.3* *175287501.3.4* *175287501.3.5*	*IT-13.1* *IT-13.2* *IT-13.5*	*Pain assessment (NQF-1637) (Non-standalone measure)* *Treatment Preferences (NQF 1641) (Non-standalone measure)* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss.*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	<u>Milestone 5 Estimated incentive payment</u>: $ 484,110			
Year 2 Estimated Milestone Bundle Amount: $1,893,343	Year 3 Estimated Milestone Bundle Amount: $1,936,438		Year 4 Estimated Milestone Bundle Amount: $1,925,437	Year 5 Estimated Milestone Bundle Amount: $1,561,160
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $7,316,378				

Project Option: 2.12.2 Implement 1 or more pilot interventions in care transitions
Title of Project: Expand Transitional Care Program for Cancer Surgery Patients

RHP Project Identification Number: 175287501.2.3 (Pass 2)
Performing Provider Name/TPI: UT Southwestern– St. Paul University Hospital /TPI 175287501

Summary Information

Summary Description: UT Southwestern proposes to expand its Transitional Care Program for Cancer Surgery Patients that it started over one year ago. We currently provide transitional care services only for Hematology-Oncology and Gynecologic Oncology patients. With additional resources from this project, the program will be expanded to include Surgical Oncology, Thoracic Surgery, Neuro-Surgery and Breast Surgery patients. The transitional care team includes physicians, mid-level providers, nurses, social workers, pharmacists, psychologists, and financial counselors.

Provider: The UT Southwestern Medical Center ("UTSW" or "UT Southwestern") operates 452 inpatient beds in the St. Paul and Zale Lipshy Hospitals and clinics on its Dallas campus. Faculty and Residents provide care to more than 100,000 hospitalized patients and oversee nearly 2 million outpatient visits a year. The Harold C. Simmons Cancer Center has National Cancer Institute (NCI) designation. The Simmons Cancer Center is the only medical center in North Texas to attain this prestigious "gold standard" status, which the NCI bestows upon the nation's top cancer centers in recognition of innovative research and excellence in patient care. The expertise of the physicians extends to every cancer, from breast, urologic, gynecologic, lung, gastrointestinal, head and neck, brain, and skin to lymphomas, leukemia, and bone marrow transplantation.

Intervention(s): Cancer surgery patients are one of many inpatient diagnostic categories that have very complex needs during the hospital stay and during their navigation of post-discharge continuum of care. The Transitional Care Services program greatly enhances collaboration and communicaton between inpatient care givers and the myriad outpatient, post-acute care, home and physician office providers. The process improves patient satisfaction, assures a tighter continuum of care for better overall outcomes, reduces the chance of re-admissions because fewer missteps are taken with nutrition, medication management, adherence to discharge instructions, physician office visit scheduling, and the patients ability to cope with everything going on with their care.

Need for Project: The RHP 9 Community Needs Assessment indicates a substantial need to improve transitional care support services. Cancer patients represent most of the highest cost ED encounters for all payors. In addition, potential preventable admissions of cancer patients are among the most expensive admissions for all payors sources. Cancer-related Medicaid and Uninsured inpatient encounter costs totaled $23,089,618 compared to the total cost for all payors of $86,421,715.

Target Population: All cancer patients treated at St. Paul University Hospital will benefit from the program. At present, between 3% and 4% of cancer patients are Medicaid or low-income patients. In FY2012, there were 2,009 cancer patient discharges, with 1,214 being hematology/oncology patients discharged from St. Paul Hospital.

Category 2 Expected Patient Benefits: By the end of DY5, it is projected that approximately 9,000 cancer patients (DY2: ~2100, DY3: ~2200, DY4: ~2300, DY 5: ~2400) will be discharged from UTSW University Hospital. Approximately 360 of those patients will be Medicaid (DY2: ~40, DY3: ~70, DY4: ~110, DY5: ~140. Cost savings for each Medicaid avoidable readmissions range from $30,000 to $164,000.

Category 3 Outcomes:

OD-3 Potentially preventable Re-Admissions- 30 day Readmission Rates
IT-3.1 All cause 30 day readmission rate

Project Description:

UT Southwestern proposes to expand its Transitional Care Program for Cancer Patients that it started over one year ago. We currently provide the transitional care services for Hematology-Oncology and Gynecologic Oncology patients. With additional resources from this project, the program will be expanded to include Surgical Oncology, Thoracic Surgery, Neuro-Surgery and Breast Surgery patients. The beneficiaries of the program have a more seamless continuum of care. The transitional care team includes physicians, mid-level providers, nurses, social workers, pharmacists, psychologists, and financial counselors.

UT Southwestern will continue to develop and improve the criteria and protocols around various discharge conditions, while identifying post-acute providers who can and will adhere to evidence-based practices. UT Southwestern will continue to identify "at risk" patients through data and risk stratification methodologies, and expand the number of Transitional Care Team members to ensure seamless post-discharge follow-up care in order to support improvement of baseline quality, cost, and other metrics. UT Southwestern will develop and implement post-discharge care management protocols targeted toward patients who are at higher risk for readmission, and ensure that patients receive post-discharge outreach according to the established protocols. The outreach protocol should at a minimum include discussion of the patient's symptoms/disease process, nutrition needs, psychological needs, medication review, inquiry regarding living environment, and confirmation of follow-up clinician appointments.

Collaboration

This project is **not** being proposed through a collaboration agreement.

Goals and Relationship to Regional Goals:

The stated goal of our project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Transitions from hospital to home or nursing home have been shown to be problematic and costly. Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. The lack of coordination that exists today has lead to avoidable hospital readmission.

Project Goals:
The project plans to expand the types of patients who receive comprehensive transitional care services. By DY5, the services will be available to all cancer patients regardless of subspecialty.

This project also meets the following regional goals:
A major goal of the region is to improve the delivery of coordinated care. This project would contribute to achieving that goal by developing and implementing post-discharge care management protocols targeted toward patients who are at higher risk for readmission, and ensure that patients receive post-discharge outreach according to the established protocols. In addition, emergency department utilization is high in RHP 9 and by providing more patients with the coordinated care they need, when they need it, this project helps achieve the a regional goal to keep patients from unnecessarily using the emergency departments and urgent care centers as a means to receive basic care.

Challenges:
Historically, at all health care systems, including UT Southwestern, patients have been discharged from the acute inpatient setting without understanding all the care that was actually provided during the admission and what risks required continued management following discharge. Patients discharged back into the community without a pre-scheduled follow-up appointment and uncertain of how to care for themselves or what complications to look for, suffer an increase risk of relapse and readmission. In addition to creating unnecessary patient confusion and suffering, providers have not coordinated these transitions effectively amongst themselves.

Another challenge associated with inefficient care transitions is the resulting economic costs. Although post-acute care spending in RHP 9 is substantially higher than the national average, we aren't seeing the expected outcomes, i.e. improved health, from those investments. We must develop strategies to improve care transition programs while limiting spending growth to the health system overall. UT Southwestern's ownership of home health services provides an opportunity to substantially improve patient and/or caretaker understanding of treatment regimen and illness prevention education, while allowing the patient to return to a familiar setting for post-acute medical care sooner.

5-Year expected outcome for Provider and Patients:

At present, between 3% and 4% of cancer patients are Medicaid or low-income patients. In FY2012, there were 2,009 cancer patient discharges, with 1,214 being hematology/oncology patients discharged from St. Paul Hospital. By the end of DY5, it is projected that approximately 9,000 cancer patients (DY2: ~2100, DY3: ~2200, DY4: ~2300, DY 5: ~2400) will be discharged from UTSW University Hospital. Approximately 360 of those patients will be Medicaid (DY2: ~40, DY3: ~70, DY4: ~110, DY5: ~140. Cost savings for each Medicaid avoidable readmissions range from $30,000 to $164,000.

In general, the 5-year expected outcome for UT Southwestern is primary care physician engagement, improved post-discharge processes and protocols, increased utilization of care coordinators and high quality/ highly educated non-physician practitioners, enhanced interpretation services, culturally educated providers, and coordinated care management. RHP 9 patients will enter the new primary care physician/patient-centric care continuum more seamlessly and with highly engaged providers. With timely post-discharge follow-up, problems with the patient's understanding and identification of possible complications can be quickly identified and addressed. Improved metrics will reflect the efforts through reduced cost, readmission rates, and improved quality outcomes. Finally, identifying and working with high quality network of post-acute providers that are committed to providing evidence-based care will improve quality and cost efficiency.

Patients will be actively supported by a broader array of healthcare professionals and processes to increase connections and checkpoints to confirm and stabilize and potentially improve their recovery. This program should improve the patient's understanding of care delivered, minimize unnecessary stress, and strengthen their role in recovery, creating a shared ownership of an improved health outlook. That engagement could also improve connections to lower cost channels and reduce ED intake.

Starting Point/Baseline:

Patients who have participated in the Transitional Care Services for Cancer Patients during the October 1, 2011 through September 30, 2012 timeframe (DY1) will be the baseline for the project. Data will be collected on their patient satisfaction scores, readmission rates, ED utilization.

Rationale:

There is evidence that care coordination and transitional care can reduce unplanned hospital readmissions, which are an indicator of quality of care and a source of significant wasted hospital resources and expenditures. Care coordination is defined by the Agency for Healthcare Research and Quality (AHRQ) as the "deliberate organization of patient care activities between two or more participants (including the patients) involved in a patient's care to facilitate the appropriate delivery of health care services Transitional care, which is complementary to care coordination, is "a broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to

another." Successful care coordination and transitional care programs have traditionally been implemented for medical rather than surgical patients and in settings where patients have ready access to primary care providers. Cancer care and outcomes are worst among racial/ethnic minorities and uninsured patients and at safetynet hospitals serving a disproportionate percentage of these patients. Cancer surgery at safety-net hospitals has been associated with delays, or failures, in receiving treatment (both surgical and adjuvant) and an increased risk of death. In addition, major postoperative complications and readmissions occur commonly among cancer surgery patients, both of which are associated with increased risk of death; readmission rates after complex surgery have been reported to be as high as 59% in one year. Transitions to home after cancer surgery can be difficult because of pain, decreased function and mobility, and surgery-related symptoms or complications. These transitions may be even more difficult among patients with limited social support, reduced health literacy, and unclear expectations regarding post-operative recovery.

Development of a seamless transition from an inpatient environment to an outpatient setting, possibly with the use of home health or palliative care services, or if appropriate a strategically selected alternative institutional setting, such as a high quality and cost effective LTAC or SNF is important for optimizing quality and efficiency. In addition to implementing primary care physician-centric information and care management models, we must ensure adequate metrics are identified and implemented to document and improve results for all constituencies, resulting in a decrease of readmissions and costly medical interventions.

ED visits from complications of cancer treatment are among the top 5 most expensive diagnostic categories for all payor sources, but tend to be higher for Medicaid and Uninsured populations according the RHP9 Community Needs Assessment. Potentially Preventable Readmissions for cancer patients are also among the most expense based on the same DFW Hospital Council analysis. Thus, there is good rationale and evidence to suggest that a comprehensive transitional care program would reduce readmissions and emergency room visits without increasing costs in high-risk surgical patients. The program could have other potential benefits such as: decreased patient anxiety and increased patient satisfaction; improved quality of care (and care coordination); improved access to specialty care; and reduced disparities in surgical and cancer-specific outcomes. If successful for cancer surgery patients, the program could be implemented for other high-risk surgical groups such as diabetic patients receiving lower extremity amputations.

<u>Project components:</u>

To accomplish UT Southwestern's of expanding improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings, UT Southwestern's project will meet all required project components listed below.

a) Use of discharge checklists,
b) Develop post-discharge medication planning,
c) Arrange post-op clinic visit before discharge,
d) Develop "Hand off" communication plans between providers,

e) Provide patient and family post-operative recovery education and wellness education, and

f) Conduct follow-up contact using automated flags and reminders.

For the Comprehensive Transitional Care Program for Cancer Surgery Patients Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines will be determined using DY1 data.

To progress towards this objective, UT Southwestern has selected a number of milestones and metrics that are relevant to the community needs and priorities of RHP 9.

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

The Transitional Care Services for Cancer Patients is a very small program when considering the entire range of patients and specialties within St. Paul University Hospital. The challenge will be to expand the program across all cancer patients, and eventually to incorporate it into the standard of care throughout the entire organization. This will require a significant amount of planning, physician and staff collaboration, additional staffing support, and the appropriate tools to track and measure progress.

Community Needs Addressed:

The specific and unique community need identification numbers that this project addresses include the following:

- CN.3: Healthcare Capacity
- CN.8: Chronic Disease
- CN.9: Specialty Care
- CN.11: Patient Safety and Quality
- CN.12: Emergency Department Usage and Readmissions
- CN-13: Palliative Care

Related Category 3 Outcome Measure(s):

OD-3 Potentially preventable Re-Admissions- 30 day Readmission Rates

IT-3.1 All cause 30 day readmission rate

Reasons/rationale for selecting the outcome measures:

With post-acute care spending in RHP 9 being substantially higher than the national average, we selected a standalone measure from the domain of potentially preventable re-admission rates. This is where we believe the impact of our project will be most measureable. Avoidable ED visits and readmissions for patients undergoing cancer care treatment are among top 5 most expensive encounter and admissions in RHP9. By reducing readmissions, the greatest impact on lowering the cost of care and raising the quality of outcomes will be measured.

Relationship to other Projects:
This project is influenced by or influences the following related projects:

- 126686802.1.7: Increase training of primary care workforce – provide CME courses to primary care providers and specialists in patient-centered medical home and chronic disease management. – this will help support the care patient receive before and after discharge.

- 126686802.1.8: Increase training of primary care workforce – train Family Medicine residents in patient centered medical home and disease management. – this will help support the care patient receive before and after discharge.

- 126686802.1.11: Expand specialty care services. – this program will help prevent avoidable ED visits by triaging and providing immediate interventions before and after hospital discharges.

- 126686802.1.12: Enhance performance improvement and reporting capacity – develop a quality improvement center. - this project support the training of staff and their efforts to improve the services they provide to patients.

- 175287501.2.1: Establish a patient care navigation program. – Establish an ED patient navigation program. – this project support better care transitions when cancer patients have an ED encounter.

- 175287501.2.2: Use of Palliative Care Programs. – supports an eliminate of transitional care.

Relationship to Other Performing Providers' Projects in the RHP: We have not seen the list of projects for Pass 2, but during Pass 1, there were two other Category 2.12 projects:

- 2.12.1 Parkland Memorial Hospital
- 2.12.2 Children's Medical Center of Dallas

Plan for Learning Collaborative: The Anchor plans to develop and facilitate Learning Collaboratives in the Region with DFW Hospital Council. UT Southwestern will participate in the Collaborative(s) as appropriate. Collaboration will be particularly important as the region seeks to document the success of primary care and primary care prevention projects across the entire population. UT Southwestern will work with Parkland and the DFW Hospital Council to document the overall impact of these initiatives.

Project Valuation:
The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total

score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criterion rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using the criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). **This project's score for this criterion: 6.00**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population. **This project's score for this criterion: 5.00**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues. **This project's score for this criterion: 5.23**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person. **This project's score for this criterion: 6.00**

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability. **This project's score for this criterion: 5.35**

Total Valuation Score for this project: **5.20**

UNIQUE CATEGORY 2 PROJECT IDENTIFIER	***PROJECT OPTION***	***REFERENCE NUMBER OF PROJECT 12.2***	**Expand Transitional Care Program for Cancer Patients**	
175287501.2.3	***2.12.2***	***N/A***		
University of Texas Southwestern University Hospitals				***TPI*** 175287501
Related Category 3 Outcome Measure:	**IT-3.12**	***175287501.3.6***	**Other - Potentially Preventable Readmission Rate for Cancer Patients**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): Develop or implement best practices or evidenced-based protocols for effectively communicating with patients and families (such as Partnership for Patients). **Metric 1.1 [P-1.1]** Submit Care Transition Protocols Baseline: Existing protocols Goal: Complete set of protocols on best practices. Data Source: Protocol manuals currently in place on Hem/Onc unit; literature on best practices. Rationale: Protocols for discharge planning and post-discharge follow up will allow for wider and more effective adoption of new practices for other patient types. **Milestone 1 Estimated Incentive Payment:** $299,074 **Milestone 2** [P-2]: Implement standardized care transition processes Metric 2.1 [P-2.1]: Care transition	**Milestone 7** [P-4]: Conduct an assessment and establish linkages with community-based organizations to create support network for targeted patients post-discharge. **Metric 7.1** [P-4.1]: Care transition assessments and linkages. Baseline: Number and quality of network linkages in DY2. Data Source: Documentation of care transition assessment and resource planning documents. **Milestone 7 Estimated Incentive Payment:** $305,882 **Milestone 8 [P-5]:** Using a validated risk assessment tool, create a patient identification system. **Metric 8.1** [P-5.1]: Documentation of a patient stratification system. Data Source: Submission of risk assessment tool and patient stratification report. Reports of findings and follow-up actions. **Milestone 8 Estimated Incentive**		**Milestone 13** [P-7]: Implement staffing plan to expand care transitions program to additional cancer patient categories. **Metric 13.1** [P-7.2]: Documentation of new staff hired to implement care transition protocols for new categories of patients. Baseline: Number of care transition FTEs in DY3. Goal: 5% capability improvement over baseline period. Data Source: Staff rosters and schedules. HR records, training records. **Milestone 13 Estimated Incentive Payment:** $915,223 **Milestone 14 [I-15]:** Improve care transitions using innovative project option. **Metric 14.1** [I-15.1]: Increase percentage of target population reached. Numerator: Number of individuals in target population reached by the innovative project.	**Milestone 17** [P-7]: Develop a staffing and implementation plan to accomplish goals/objectives of the care transitions program. **Metric 17.1** [P-7.2]: Documentation of the staffing plan - *new staff hired to implement care transition protocols for new categories of patients.* Baseline: Number of care transition FTEs in DY4. Goal: 5% capability improvement over baseline period. Data Source: Staff rosters and schedules. HR records, training records. **Milestone 17 Estimated Incentive Payment:** $295,923 **Milestone 18 [I-15]:** Improve care transitions using innovative project option. Metric 18.1[I-15.1]: Increase percentage of target population reached.

UNIQUE CATEGORY 2 PROJECT IDENTIFIER *175287501.2.3*	*PROJECT OPTION* *2.12.2*	*REFERENCE NUMBER OF PROJECT 12.2* *N/A*	**Expand Transitional Care Program for Cancer Patients**	
University of Texas Southwestern University Hospitals				***TPI*** 175287501
Related Category 3 Outcome Measure:	**IT-3.12**	***175287501.3.6***	**Other - Potentially Preventable Readmission Rate for Cancer 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)**
policies and procedures. Baseline: N/A. Goal: Submission of protocols. Data Source: Policies and procedures of care transition program materials. **Milestone 2 Estimated Incentive Payment:** $299,074 **Milestone 3** [P-2]: Implement standardized care transition protocols. Metric 3.1 [P-2.1]: Documentation of protocol implementation training and tracking protocol applications. Baseline: Schedule for implementing new protocols Goal: Documentation of consistent use of protocols on designated nursing unit. Data Source: Periodic surveys of protocol utilization. **Milestone 3 Estimated Incentive Payment:** $299,074 **Milestone 4 [P-3]:** Establish a process for hospital-based case managers to follow-up with identified patients	**Payment:** $305,882 **Milestone 9 [I-10]:** Identify the top chronic conditions and other patient characteristics that are common causes of avoidable readmissions for each type of cancer patient. **Metric 9.1** [I-10.1]: Identification and report of those conditions and factors Goal: Submit completed report. Data Source: Registry or EHR reports or analysis. **Milestone 9 Estimated Incentive Payment:** $305,882 **Milestone 10 [I-11]:** Improve the percentage of patients in the defined population receiving standardized care according to the approved clinical protocols. **Metric 10.1** [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions. Numerator: Number of patients that receive all recommended education, care, and services as dictated by guidelines. Denominator: Number of patients		Denominator: Number of individuals in the target population. Goal: 10% improvement over DY3 Data Source: Documentation of target population reached, as designated in the project plan. **Metric 14.2** [I-15.2]: Evaluate the interventions. Numerator: number of patients transitioned by type of transition. Denominator: total number of patients transitioned. Goal: 10% improvement of DY3 Data Source: data file of all transitioned patients in one year. **Metric 14.3** [I-15.3]: Percentage of patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24-hours of discharge. Numerator: number of patients for whom a record was transmitted with 24-hours of discharge. Denominator: Total number of patients discharged from	Numerator: Number of individuals in target population reached by the innovative project. Denominator: Number of individuals in the target population. Goal: 10% improvement over DY4 Data Source: Documentation of target population reached, as designated in the project plan. **Milestone 18 Estimated Incentive Payment:** $295,323 **Milestone 19 [I-15]:** Improve care transitions using innovative project option. Metric 19.1 [I-15.2]: Evaluate the interventions. Numerator: number of patients transitioned by type of transition. Denominator: total number of patients transitioned. Goal: 10% improvement over DY4 Data Source: data file of all transitioned patients in one year. **Milestone 18 Estimated Incentive**

UNIQUE CATEGORY 2 PROJECT IDENTIFIER *175287501.2.3*	*PROJECT OPTION* *2.12.2*	*REFERENCE NUMBER OF PROJECT 12.2* *N/A*	**Expand Transitional Care Program for Cancer Patients**	
University of Texas Southwestern University Hospitals				***TPI*** 175287501
Related Category 3 Outcome Measure:	**IT-3.12**	***175287501.3.6***	**Other - Potentially Preventable Readmission Rate for Cancer 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)**
hospitalized related to hematology-oncology conditions to provide updated standardized discharge instructions and patient education. **Metric 4.1:** [P-3.1]: Care transition protocols used to follow-up with identified patients. Goal: Completed protocols and program materials. Data Source: Care transition program materials, New Policies and Procedures for Discharge Instructions. Rationale: Patient education around discharge and transitional care will ensure patients, family members and others are better able to self-manage follow-up care. **Milestone 4 Estimated Incentive Payment:** $299,075 **Milestone 5 [P-7]** Develop a staffing and Implementation Plan to accomplish the goals and objectives of care transitions program for cancer patient categories. **Metric 5.1 [P-7.1**]: Documented of		discharged or eligible for care transition services. Goal: 10% improvement of DY2 Data Source: Registry or EHR analysis. **Milestone 10 Estimated Incentive Payment:** $305,882 **Milestone 11 [P-14]:** Implement standard care transition processes in a new specified patient population. Metric 11.1 [P-1.1]: Measure adherence to processes. Numerator: Number of patients in defined population receiving care according to protocol. Denominator: Number of targeted patients. Data Source: Hospital data and EHR analysis. **Milestone 11 Estimated Incentive Payment:** $305,882 **Milestone 12** [P-7]: Implement staffing plan to expand care transitions program to additional	participating unit. Goal: 10% improvement over DY3. Data Source: data file of all transitioned patients in one year. **Milestone 14 Estimated Incentive Payment:** $915,224	**Payment:** $295,923 **Milestone 20 [I-15]:** Improve care transitions using innovative project option. Metric 20.1 [I-15.2]: Evaluate the interventions. Numerator: number of patients transitioned by type of transition. Denominator: total number of patients transitioned. Goal: 10% improvement over DY4 Data Source: EHR, data file of all transitioned patients in one year. **Milestone 20 Estimated Incentive Payment:** $295,923 **Milestone 21[I-15]:** Improve care transitions using innovative project option. **Metric 21.1** [I-15.3]: Percentage of patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for

UNIQUE CATEGORY 2 PROJECT IDENTIFIER	***PROJECT OPTION***	***REFERENCE NUMBER OF PROJECT 12.2***	**Expand Transitional Care Program for Cancer Patients**	
175287501.2.3	***2.12.2***	***N/A***		
University of Texas Southwestern University Hospitals				***TPI*** 175287501
Related Category 3 Outcome Measure:	**IT-3.12**	***175287501.3.6***	**Other - Potentially Preventable Readmission Rate for Cancer 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)**
staff planning. Goal: Completed staffing and implementation plan. Data Source: Staffing and implementation plan. **Milestone 5 Estimated Incentive Payment:** $299,075 **Milestone 6 [P-9]:** Implement a case management registry. Metric 6.1 [P-9.1]: Documentation of registry implementation. Goal: Documented start of registry implementation. Data Source: Registry reports. **Milestone 6 Estimated Incentive Payment:** $299,075		cancer patient categories. **Metric 12.1** [P-7.2]: Documentation of new staff hired to implement care transition protocols for new categories of patients. Baseline: Number of care transition FTEs in DY2. Goal: 5% capability improvement over DY2. Data Source: Staff rosters and schedules. HR records, training records. **Milestone 12 Estimated Incentive Payment:** $305,883		follow-up care within 24-hours of discharge. Numerator: number of patients for whom a record was transmitted with 24-hours of discharge. Denominator: Total number of patients discharged from participating unit. Goal: 10% improvement over DY3. Data Source: data file of all transitioned patients in one year. **Milestone 21 Estimated Incentive Payment:** $295,924
Year 2 Estimated Milestone Bundle Amount: **$1,794,447**		Year 3 Estimated Milestone Bundle Amount: **$1,835,293**	Year 4 Estimated Milestone Bundle Amount: **$1,830,447**	Year 5 Estimated Milestone Bundle Amount: **$1,479,616**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***: $6,939,803**				

E. Category 3: Quality Improvements

Title of Outcome Measure: (Improvement Target): IT-1.7 **-** Controlling High Blood Pressure (NCQA-HEDIS, 2012, NQF 0018) (Standalone)

Unique RHP Outcome Identification Number: 195018001.3.1

Performing Provider Name: Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton/ 195018001

Outcome Description

IT-1.7: Controlling high blood pressure *(Standalone measure)*

- Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year
- Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension

As one of our primary care metrics we chose blood pressure. As high blood pressure is a prerequisite to many other chronic illnesses and serious medical conditions, getting BP under control with proper PCP supervision, medications and regular visits can help patients' quality of life and overall health.

We will be monitoring these metrics closely and evaluate improvements that may need to be made. We do not have a baseline for these metrics and have relied on historical performance and improvement opportunities of other Baylor Clinics on other Baylor campuses to shape our outcomes.

By the end of the waiver, our goal is to have > 50.4% (or minimum of 2.4% total improvement over baseline) of patients who are Baylor Clinic at Baylor Medical Center at Carrollton have good blood pressure control (< 140/80 mmHg). However, the actual improvement and impact that we will have on this population will be dependent on the illness severity and quantity of patients we receive in our clinic. All improvements are listed as an absolute improvement (estimated on historical performance) and relative improvement that we expect regardless of baseline. Improvement targets may look low. This is due to: 1) establishment of a new clinic with no historical data and 2) uncertainty around disease severity of Carrollton patients.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - We will engage in project planning- we will engage stakeholders, identify current capacity and needed resources. We will determine timelines and document implementation plans

- DY3:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3: Develop and Test Data Systems
    - We will continue to engage in project planning and operationalize the clinic through hiring staff, securing capital expenditures, setting up data collection processes, etc.

Improvement Milestones

- DY4:
  - IT-1.7: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)
    - Our goal is increase the % of patients that have BP control (< 140/80 mmHg) to 47.8% (or a minimum of 1.2% improvement over baseline)
- DY5:
  - IT-1.7: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)
    - Our goal is increase the % of patients that have BP control (< 140/80 mmHg) to 50.4% (or 2.4% improvement over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Our metrics and milestones are designed to increase improvement in BP control for the target population and are based off historical performance of a similar Baylor Clinic. Actual performance and improvement will not be determined until DY4, when the clinic is operational.

Controlling high blood pressure is essential in avoiding heart attacks, stroke, heart failure and a multitude of other diseases and complications. Through medication management, proper primary care attention and education, patients can achieve better blood pressure control in the outpatient setting. In Region 9, Hypertension was identified as one of the top 5 most prevalent diseases in the area for ED visits.[391] A recent article in the New York Times suggested that hypertensive complications can be especially deadly in the African American population, who make up 22.5% of the RHP 9 population[392] and 9% of the Denton County population.[393] Blood pressure is a standard metric that all Baylor Clinics monitor and regulate. Patients who are uncontrolled will receive the attention they need to get their hypertension under control.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

For this particular project, we also accounted for the fact that Category 3 outcomes will not begin until DY4 and because this clinic will be a new endeavor, the clinical impact may not be fully realized until be realized until after DY5.

Related Category 1 and/or 2 projects

195018001.1.1: Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved (Baylor Carrollton)

[391] RHP 9 Community Health Needs Assessment
[392] http://health.nytimes.com/health/guides/disease/hypertension/complications.html
[393] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/48121.html

195018001.3.1	*3.IT-1.7*	*Controlling high blood pressure*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.1.1- Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY4 but a similar Baylor Clinic had 45.0% of patients with controlled BP (130/80 mmHg) during the first years of operation* ***Target Population:*** *Underserved/uninsured patients in Carrollton without a PCP with uncontrolled BP (>140/80 mmHg)*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 11,255	**Process Milestone 2** [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete all plans Data Source: Documentation of planning reports Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 6,523 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Ensure that Clinic is in the E.H.R and able to track data Data Source: Documentation of system readiness Process Milestone 3 Estimated Incentive Payment *(maximum*	**Outcome Improvement Target 1** [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone) Improvement Target: > 47.8% (or minimum of 1.2% improvement over baseline) of patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $20,934	**Outcome Improvement Target 2** [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone) Improvement Target: > 50.4% (or minimum of 2.4% improvement over baseline) of patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $50,060

195018001.3.1	*3.IT-1.7*	*Controlling high blood pressure*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.1.1- Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY4 but a similar Baylor Clinic had 45.0% of patients with controlled BP (130/80 mmHg) during the first years of operation* ***Target Population:*** *Underserved/uninsured patients in Carrollton without a PCP with uncontrolled BP (>140/80 mmHg)*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	amount): $ 6,523		
Year 2 Estimated Outcome Amount: $11,255	Year 3 Estimated Outcome Amount: $13,046	Year 4 Estimated Outcome Amount: $20,934	Year 5 Estimated Outcome Amount: $50,060
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $95,295			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores (Standalone measure)

1) Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Clinic Wait Times

Unique RHP Outcome Identification Number: 195018001.3.2

Performing Provider Name/TPI: Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton/ 195018001

Outcome Description

IT-6.1: 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. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(1) are getting timely care, appointments, and information; ***(Standalone measure)***

(2) how well their doctors communicate; *(Standalone measure)*

(3) patient's rating of doctor access to specialist; *(Standalone measure)*

(4) patient's involvement in shared decision making, and *(Standalone measure)*

(5) patient's overall health status/functional status. *(Standalone measure)*

Patient satisfaction is an important part of overall treatment and encourages participation and compliance of patients' in their own care. For this metric we will be measuring is to improve the satisfaction scores in regards to clinic wait times.

Establishing high patient satisfaction scores will be important at the Baylor Clinic on the Baylor Medical Center at Carrollton campus in order to ensure patients come and continue to come to the clinic to receive the care they need. We will be monitoring these metrics closely and evaluate improvements that may need to be made. We do not have a baseline for these metrics and have relied on historical performance and improvement opportunities of other Baylor Clinics on other Baylor campuses to shape our outcomes. All improvements are listed as an absolute improvement (estimated on historical performance) and relative improvement that we expect regardless of baseline. Improvement targets may look low. This is due to: 1)

establishment of a new clinic with no historical data and 2) uncertainty around disease severity/dissatisfaction of primary care services of Carrollton patients.

By the end of the waiver, our goal is to have the Baylor Clinic at Baylor Medical Center at Carrollton obtain a patient satisfaction score of 82.0% (or 2% improvement over established baseline) on the survey question related to wait time to appointment satisfaction. This falls under metric (1)- patients are getting timely care, appointments and information of 3.6.1, option (1).

Process Milestones:

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will engage in project planning- we will engage stakeholders, identify current capacity and needed resources. We will determine timelines and document implementation plans
- DY3:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-3: Develop and Test Data Systems
        - We will continue to engage in project planning and operationalize the clinic through hiring staff, securing capital expenditures, setting up data collection processes, setting up data collection processes, etc.

Improvement Milestones:

- DY4:
    - IT-6.1: Percent improvement of patient satisfaction scores
        - Our goal is increase the % of patient satisfaction related to wait times to 81.0% (or <u>minimum</u> of 1% improvement over baseline)
- DY5:
    - IT-6.1: Percent improvement of patient satisfaction scores
        - Our goal is increase the % of patient satisfaction related to wait times to 82.0% (or <u>minimum</u> of 2% improvement over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

The new Baylor Clinic at the Baylor Medical Center at Carrollton will not have any baseline data until patients are seen in DY4. In DY2 and DY3 we will be establishing the physical space, securing staff, resources and operations for the clinic. Until we start seeing patients in DY4, we will not know what our baseline for patient satisfaction will be. Thus we included relative improvements over baseline to account for actual improvement that will occur

Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Data from Press Ganey Associates in 2007 has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease[394]. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less physician/staff time, reducing length of visits and wait times for the overall practice. Baylor Clinics have historically had high performance in all measures related to patient satisfaction; however there is opportunity for improvement. This outcome has an impact on the region through increasing utilization of outpatient based primary care. If patients are satisfied, they will continue to come to their appointments, stay healthier and stay out of the ED. We anticipate that we will be able to raise patient satisfaction in the domains mentioned below through the Baylor Clinic primary care model.

1) Patients are getting timely care, appointments and information (Standalone measure): We will measure this particular metric through monitoring and improving the survey question around improving clinic wait times for patients

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was

[394] Drain, M., & Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome, involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

For this particular project, we also accounted for the fact that Category outcomes will not begin until DY4 and because this clinic will be a new endeavor, the clinical impact may not be fully realized until beyond DY5.

Related Category 1 and/or 2 projects

195018001.1.1- Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved

195018001.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton	*195018001*

Related Category 1 or 2 Projects:	*195018001.1.1- Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved*
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again* ***in DY4****. Historic data of similar Baylor Clinics show a baseline of 80% patient satisfaction (estimated baseline) during the starting years of a similar clinic's operations* ***Target Population:*** *Underserved/uninsured patients of the future Baylor Clinic in the Carrollton area*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 4,221	**Process Milestone 2** [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete all plans Data Source: Documentation of planning reports Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 2,446 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Ensure that Clinic is in the E.H.R and able to track data Data Source: Documentation of system readiness Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 2,446	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 81.0% (or minimum 1% improvement over established baseline) satisfaction with clinic wait times will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $7,850	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 82.0% (or minimum 2% improvement over established baseline) satisfaction with clinic wait times will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 18,773

195018001.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton	*195018001*

Related Category 1 or 2 Projects:	*195018001.1.1- Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved*
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again* ***in DY4****. Historic data of similar Baylor Clinics show a baseline of 80% patient satisfaction (estimated baseline) during the starting years of a similar clinic's operations* ***Target Population:*** *Underserved/uninsured patients of the future Baylor Clinic in the Carrollton area*

Year 2 (10/1/2012 – 9/30/2013)	**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: $ 4,221	Year 3 Estimated Outcome Amount: $ 4,892	Year 4 Estimated Outcome Amount: $ 7,850	Year 5 Estimated Outcome Amount: $ 18,773

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 35,736

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores (**Standalone measure)**

2) Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Response Time to Patient Phone Calls

Unique RHP Outcome Identification Number: 195018001.3.3

Performing Provider Name/TPI: Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton/ 195018001

Outcome Description

IT-6.1: 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. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(1) are getting timely care, appointments, and information; *(Standalone measure)*

(2) how well their doctors communicate; ***(Standalone measure)***

(3) patient's rating of doctor access to specialist; *(Standalone measure)*

(4) patient's involvement in shared decision making, and *(Standalone measure)*

(5) patient's overall health status/functional status. *(Standalone measure)*

Patient satisfaction is an important part of overall treatment and encourages participation and compliance of patients' in their own care. For this metric we will be measuring improvement in the responsiveness to patient phone calls in a timely manner.

Establishing high patient satisfaction scores will be important at the Baylor Clinic on the Baylor Medical Center at Carrollton campus in order to ensure patients come and continue to come to the clinic to receive the care they need. We will be monitoring these metrics closely and evaluate improvements that may need to be made. We do not have a baseline for these metrics and have relied on historical performance and improvement opportunities of other Baylor Clinics on other Baylor campuses to shape our outcomes. All improvements are listed as an absolute improvement (estimated on historical performance) and relative improvement that we expect regardless of baseline. Improvement targets may look low. This is due to: 1) establishment of a new clinic with no historical data and 2) uncertainty around disease severity/dissatisfaction of primary care services of Carrollton patients.

By the end of the waiver, our goal is to have the Baylor Clinic at Baylor Medical Center at Carrollton obtain a patient satisfaction score of 86.5% (or minimum 1.7% total improvement over established baseline) on the survey question related to patient phone calls being returned in a timely fashion. This falls under metric (2) Patients are getting timely care, appointments and information of 3.6.1, option (2).

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - We will engage in project planning- we will engage stakeholders, identify current capacity and needed resources. We will determine timelines and document implementation plans.
- DY3:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3: Develop and test data systems
    - We will continue to engage in project planning and operationalize the clinic through hiring staff, securing capital expenditures, setting up data collection processes, etc.

Improvement Milestones

- DY4:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - Our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 85.8% (or minimum 1% improvement over established baseline)
- DY5:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - Our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 86.5% (or minimum 1.7% total improvement over established baseline)

<u>Rationale</u>

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an

ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

The new Baylor Clinic at the Baylor Medical Center at Carrollton will not have any baseline data until patients are seen in DY4. In DY2 and DY3 we will be establishing the physical space, securing staff, resources and operations for the clinic. Until we start seeing patients in DY4, we will not know what our baseline for patient satisfaction will be.

Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Data from Press Ganey Associates in 2007 has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease[395]. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less physician/staff time, reducing length of visits and wait times for the overall practice. Baylor Clinics have historically had high performance in all measures related to patient satisfaction; however there is opportunity for improvement. This outcome has an impact on the region through increasing utilization of outpatient based primary care. If patients are satisfied, they will continue to come to their appointments, stay healthier and stay out of the ED. We anticipate that we will be able to raise patient satisfaction in the domains mentioned below through the Baylor Clinic primary care model.

2) Patients are getting timely care, appointments and information (Standalone measure): We will measure this particular metric through monitoring and improving the survey question around response times to patient phone calls

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to

[395] Drain, M., & Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

For this particular project, we also accounted for the fact that Category 3 outcomes will not begin until DY4 and because this clinic will be a new endeavor, the clinical impact may not be fully realized until beyond DY5.

Related Category 1 and/or 2 projects

195018001.1.1- Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved

195018001.3.3	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.1.1- Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY4. Historic data of similar Baylor Clinics show a baseline of 85% patient satisfaction (estimated baseline)* ***Target Population:*** *Underserved/uninsured patients of the future Baylor Clinic in the Carrollton area*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 4,221	**Process Milestone 2** [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete all plans Data Source: Documentation of planning reports Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 2,446 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Ensure that Clinic is in the E.H.R and able to track data Data Source: Documentation of system readiness Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 2,446	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 85.8% (or minimum 1% improvement over established baseline) satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 7,850	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 86.5% (or minimum 1.7% improvement over established baseline) satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 18,773

195018001.3.3	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton	*195018001*
Related Category 1 or 2 Projects:	*195018001.1.1- Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved*
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY4. Historic data of similar Baylor Clinics show a baseline of 85% patient satisfaction (estimated baseline)* ***Target Population:*** *Underserved/uninsured patients of the future Baylor Clinic in the Carrollton area*

Year 2 (10/1/2012 – 9/30/2013)	**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: $ 4,221	Year 3 Estimated Outcome Amount: $ 4,892	Year 4 Estimated Outcome Amount: $ 7,850	Year 5 Estimated Outcome Amount: $ 18,773
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 35,736			

Title of Outcome Measure (Improvement Target): IT-12.1 Breast Cancer Screening (Non-Standalone)

Unique RHP Outcome Identification Number: 195018001.3.4

Performing Provider Name/TPI: Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton/ 195018001

Outcome Description

IT-12.1: Breast Cancer Screening (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

Breast Cancer screening is a preventive measure that is part of the standard protocols and procedures for Baylor Clinic patients. Ensuring that the age appropriate and necessary screenings are completed in a timely manner help keep patients healthy. By the end of the waiver, our goal is to have > 41.3% (or a minimum of 3% total improvement over established baseline) of women ages 40-69 who are patients of the Baylor Clinic at Baylor Medical Center at Carrollton to have a breast cancer screening. We will be monitoring these metrics closely and evaluate improvements that may need to be made. We do not have a baseline for these metrics and have relied on historical performance and improvement opportunities of other Baylor Clinics on other Baylor campuses to shape our outcomes. All improvements are listed as an absolute improvement (estimated on historical performance) and relative improvement that we expect regardless of baseline. Improvement targets may look low. This is due to: 1) establishment of a new clinic with no historical data and 2) uncertainty around disease severity/lack of primary care services of Carrollton patients.

Process Milestones:

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will engage in project planning- we will engage stakeholders, identify current capacity and needed resources. We will determine timelines and document implementation plans

- DY3:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-3: Develop and Test Data Systems
        - We will continue to engage in project planning and operationalize the clinic through hiring staff, securing capital expenditures, setting up data collection processes, etc.

Improvement Milestones

- DY4:
    - IT-12.1: Breast Cancer Screening (HEDIS 2012) (Non-Standalone)
        - Our goal is increase the % of patients have had a breast cancer screen to at least 38.3% (or minimum 1.5% improvement over established baseline)
- DY5:
    - IT-12.1: Breast Cancer Screening (HEDIS 2012) (Non-Standalone)
        - Our goal is increase the % of patients have had a breast cancer screen to at least 41.3% (or a minimum of 3% improvement over established baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

The new Baylor Clinic at the Baylor Medical Center at Carrollton will not have any baseline data until patients are seen in DY4. In DY2 and DY3 we will be establishing the physical space, securing staff, resources and operations for the clinic. Until we start seeing patients in DY4, we will not know what our baseline for breast cancer screening will be.

In Denton County, the incidence rate of breast cancer is 126.6 cases/100,000 females, much higher than the Dallas County rate of 23.7/100,000. This statistic is considered to be way higher

than the national average. There is room for improvement with this metric to screen more women and utilize early detection methods for breast cancer.[396]

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

For this particular project, we also accounted for the fact that Category 3 outcomes will not begin until DY4 and because this clinic will be a new endeavor, the clinical impact may not be fully realized until beyond DY5.

Related Category 1 and/or 2 projects

195018001.1.1 Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved

[396] Healthy North Texas: www.healthyntexas.org

195018001.3.4	*3.IT-12.1*	*Breast Cancer Screening*
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton		*195018001*
Related Category 1 or 2 Projects:	*195018001.1.1- Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved*	
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in* ***DY4****. Historic data of similar Baylor Clinics show a baseline of 38.3% of women who received breast cancer screening (estimated baseline) during the starting years of a similar clinic's operations* ***Target Population:*** *Underserved women in Carrollton that are over the age of 40*	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 7,034	**Process Milestone 2** [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete all plans Data Source: Documentation of planning reports Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 4,077 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Ensure that Clinic is in the E.H.R and able to track data Data Source: Documentation of system readiness Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 4,077	**Outcome Improvement Target 1** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone) Improvement Target: > 38.3% (or minimum of 1.5% improvement over baseline) of women over the age of 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 13,084	**Outcome Improvement Target 2** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone) Improvement Target: > 41.3% (or minimum of 3% improvement over baseline) of women over the age of 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 31,288

195018001.3.4	*3.IT-12.1*	*Breast Cancer Screening*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.1.1- Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in* ***DY4****. Historic data of similar Baylor Clinics show a baseline of 38.3% of women who received breast cancer screening (estimated baseline) during the starting years of a similar clinic's operations* ***Target Population:*** *Underserved women in Carrollton that are over the age of 40*		
Year 2 (10/1/2012 – 9/30/2013)	**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: $ 7,034	Year 3 Estimated Outcome Amount: $ 8,154	Year 4 Estimated Outcome Amount: $ 13,084	Year 5 Estimated Outcome Amount: $ 31,288
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 59,560			

Title of Outcome Measure (Improvement Target): IT-12.5 Other USPSTF-endorsed screening outcome measures (Non-Standalone): Influenza Vaccination Rate

Unique RHP Outcome Identification Number: 195018001.3.5

Performing Provider Name/TPI: Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton/ 195018001

Outcome Description

IT-12.5: Other USPSTF-endorsed screening outcome measures

As part of primary care, the influenza vaccine is a simple, cost effective way for patients to protect themselves from the flu and other potential clinical exacerbations. We will be monitoring these metrics closely and evaluate improvements that may need to be made. We do not have a baseline for these metrics and have relied on historical performance and improvement opportunities of other Baylor Clinics on other Baylor campuses to shape our outcomes. All improvements are listed as an absolute improvement (estimated on historical performance) and relative improvement that we expect regardless of baseline. Improvement targets may look low. This is due to: 1) establishment of a new clinic with no historical data and 2) uncertainty around disease severity/lack of primary care services of Carrollton patients.

By the end of the waiver, our goal is to have > 63.9% (or minimum of 1.9% total improvement over baseline) of Baylor Clinic patients over the age of 18 receive an influenza vaccination.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will engage in project planning- we will engage stakeholders, identify current capacity and needed resources. We will determine timelines and document implementation plans
- DY3:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-3: Develop and Test Data Systems
        - We will continue to engage in project planning and operationalize the clinic through hiring staff, securing capital expenditures, setting up data collection processes, etc.

Improvement Milestones

- DY4:
    - IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone)
        - Our goal is increase the % of patients >18 years old that have had an influenza vaccination in the past 12 months to 62.0% (or minimum of 1% improvement over established baseline)
- DY5:
    - IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone)
        - Our goal is increase the % of patients >18 years old that have had an influenza vaccination in the past 12 months to 63.9% (or minimum of 1.9% total improvement over established baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

The new Baylor Clinic at the Baylor Medical Center at Carrollton will not have any baseline data until patients are seen in DY4. In DY2 and DY3 we will be establishing the physical space, securing staff, resources and operations for the clinic. Until we start seeing patients in DY4, we will not know what our baseline for influenza vaccinations.

In Denton County, there are 32.6 deaths/100,000 people due to influenza and pneumonia. This rate is much higher than the national average of 19.6.[397] The rate of African American age adjusted death rate due to influenza/pneumonia is 70.8 deaths/ 100,000, two times greater than the Caucasian rate in Denton County.[398] The rate of influenza vaccinations in the Region is quite low and there is an opportunity to increase the number in the target population that receive this basic vaccination in order to prevent exacerbations of health issues, reduce the prevalence of influenza and prevent ED visits related to influenza that can otherwise be handled in an outpatient setting.

[397] RHP 9 Community Health Needs Assessment
[398] Healthy North Texas: www.healthyntexas.org

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

For this particular project, we also accounted for the fact that Category 3 outcomes will not begin until DY4 and because this clinic will be a new endeavor, the clinical impact may not be fully realized until beyond DY5.

Related Category 1 and/or 2 projects

195018001.1.1 Establish More Primary Cre Clinics-Create New Baylor Clinic for Underserved

195018001.3.5	*IT-12.5*	*Other USPSTF-endorsed screening outcome measures (Influenza Vaccination)*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.1.1- Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in* ***DY4*** *but a similar Baylor Clinic had 60.0% of patients over the age of 18 receive an influenza vaccination* ***Target Population:*** *Underserved/uninsured patients 18 years and older in Denton County(Carrollton)*		

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 7,034	**Process Milestone 2** [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete all plans Data Source: Documentation of planning reports Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 4,077 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Ensure that Clinic is in the E.H.R and able to track data Data Source: Documentation of system readiness Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 4,077	**Outcome Improvement Target 1** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone) Improvement Target: > 62.0% (or minimum of 1% improvement over baseline) of patients over the age of 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 13,084	**Outcome Improvement Target 2** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone) Improvement Target: > 63.9% (or minimum of 1.9% improvement over baseline) of patients over the age of 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ $31,288

195018001.3.5	*IT-12.5*	*Other USPSTF-endorsed screening outcome measures (Influenza Vaccination)*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.1.1- Establish More Primary Care Clinics-Create New Baylor Clinic for Underserved*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in* ***DY4*** *but a similar Baylor Clinic had 60.0% of patients over the age of 18 receive an influenza vaccination* ***Target Population:*** *Underserved/uninsured patients 18 years and older in Denton County(Carrollton)*		
Year 2 (10/1/2012 – 9/30/2013)	**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: $ 7,034	Year 3 Estimated Outcome Amount: $ 8,154	Year 4 Estimated Outcome Amount: $ 13,084	Year 5 Estimated Outcome Amount: $ 31,288
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 59,560			

Title of Outcome Measure (Improvement Target): IT-12.2 Cervical Cancer Screening (HEDIS 2012) (Non-Standalone Measure)

Unique RHP Outcome Identification Number: 195018001.3.6

Performing Provider Name/TPI: Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton/ 195018001

Outcome Description

IT-12.2: Cervical Cancer Screening (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.

As part of preventive care and screenings, cervical cancer screening is a standard practice that Baylor primary care clinics provide for their patients. Education and regular exams can be the difference between early detection and death.

We will be monitoring these metrics closely and evaluate improvements that may need to be made. We do not have a baseline for these metrics and have relied on historical performance and improvement opportunities of other Baylor Clinics on other Baylor campuses in their preliminary years of operations to shape our outcomes.

By the end of the waiver, our goal is to have > 54.9% (or minimum improvement of 2.4% over baseline) of patients who are Baylor Clinic at Baylor Medical Center at Carrollton be screened for Cervical Cancer. However, the actual improvement and impact that we will have on this population will be dependent on the illness severity and quantity of patients we receive in our clinic.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will engage in project planning- we will engage stakeholders, identify current capacity and needed resources. We will determine timelines and document implementation plans

- DY3:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-3: Develop and Test Data Systems
        - We will continue to engage in project planning and operationalize the clinic through hiring staff, securing capital expenditures, setting up data collection processes, etc.

Improvement Milestones

- DY4:
    - IT-12.2: Cervical Cancer Screening
        - Our goal is increase the % of patients that have received a Cervical Cancer screening to at least 52.5% (or a minimum of 1.2% improvement over baseline)
- DY5:
    - IT-12.2: Cervical Cancer Screening
        - Our goal is increase the % of patients that have received a Cervical Cancer screening to at least 54.9% (or a minimum of 2.4% improvement over baseline)

As we establish the Baylor Clinic on the Baylor Medical Center at Carrollton campus, we will aim to work with both primary care and specialty care physicians to become integrated parts of the care team. We hope in DY4 and DY5 these physicians will work together in order to meet these improvement targets around cervical cancer screening, prevention and education. We feel that OB/GYNs should handle more complex cases but also use this opportunity to help educate underserved women about the importance of screenings and prevention.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Metrics selected were based on historical data from similar programs with specialty care providers that showed material improvement in a 2-3 year time period.

Our metrics and milestones are designed to increase improvement in Cervical Cancer screenings for the target population in Carrollton and are based off historical performance of a similar Baylor Clinic. Actual performance and improvement will not be determined until DY4, when the clinic is operational.

In Region 9, the incidence rate of cervical cancer is higher than the national average. In Denton County, the incidence rate of cervical cancer is 5.9 cases per 100,000 people.[399] According to the National Cancer Institute, African American women are more likely to be diagnosed with cervical cancer and Hispanic women have the highest cervical cancer incidence rate amongst all women.[400] There is opportunity to increase the screenings in the minority population through engaging OB/GYNs to provide screenings and education for this population. Additionally, these specialists can provide the advanced screenings and education that would not be available in a primary care setting.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

For this particular project, we also accounted for the fact that Category 3 outcomes will not begin until DY4 and because this clinic will be a new endeavor, the clinical impact may not be fully realized until beyond DY5.

Related Category 1 and/or 2 projects

195018001.1.2- Improve Access to Specialty Care-Expand Specialty Care Services

[399] Healthy People North Texas: http://www.healthyntexas.org

[7] National Cancer Institute: http://www.cancer.gov/

195018001.3.6	*3.IT-12.2*	*Cervical Cancer Screening*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.1.2*- Improve Access to Specialty Care-Expand Specialty Care Services		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in* ***DY4****. Historic data of similar Baylor Clinics show a baseline of 50% cervical cancer screening rate (estimated baseline) during the starting years of a similar clinic's operations* ***Target Population:*** *Underserved/uninsured women between the ages of 21-64 in Carrollton*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 4,288	**Process Milestone 2** [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete all plans Data Source: Documentation of planning reports Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 2,485 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Ensure that Clinic is in the E.H.R and able to track data Data Source: Documentation of system readiness Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 2,485	**Outcome Improvement Target 1** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 52.5% (or minimum of 1.2% improvement over baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 7,975	**Outcome Improvement Target 2** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 54.9% (or minimum 2.4% improvement over baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 19,071

195018001.3.6	*3.IT-12.2*	*Cervical Cancer Screening*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.1.2*- Improve Access to Specialty Care-Expand Specialty Care Services		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in* ***DY4****. Historic data of similar Baylor Clinics show a baseline of 50% cervical cancer screening rate (estimated baseline) during the starting years of a similar clinic's operations* ***Target Population:*** *Underserved/uninsured women between the ages of 21-64 in Carrollton*		
Year 2 (10/1/2012 – 9/30/2013)	**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): $ 4,288	Year 3 Estimated Outcome Amount: $ 4,970	Year 4 Estimated Outcome Amount: $ 7,975	Year 5 Estimated Outcome Amount: $ 19,071
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 36,304			

Title of Outcome Measure (Improvement Target): IT-12.3 - Colorectal Cancer Screening (HEDIS 2012) (Non-Standalone Measure)

Unique RHP Outcome Identification Number: 195018001.3.7

Performing Provider Name/TPI: Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton/ 195018001

Outcome Description

IT-12.3 Colorectal Cancer Screening (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.

As part of preventive care and screenings, colorectal cancer screening is a standard practice that Baylor primary care clinics provide for their patients. Education and regular exams can be the difference between early detection and death.

We will be monitoring these metrics closely and evaluate improvements that may need to be made. We do not have a baseline for these metrics and have relied on historical performance and improvement opportunities of other Baylor Clinics on other Baylor campuses in their preliminary years of operations to shape our outcomes.

By the end of the waiver, our goal is to have > 27.8% (or a minimum of 3.8% improvement over baseline) of patients who are Baylor Clinic patients at Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton be screened for Colorectal Cancer.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will engage in project planning- we will engage stakeholders, identify current capacity and needed resources. We will determine timelines and document implementation plans
- DY3:

- P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-3: Develop and Test Data Systems
  - We will continue to engage in project planning and operationalize the clinic through hiring staff, securing capital expenditures, setting up data collection processes, etc.

Improvement Milestones

- DY4:
  - IT-12.3 Colorectal Cancer Screening
    - Our goal is increase the % of patients that have received a Colorectal Cancer screening to at least 24.0% (or minimum of 1.9% improvement over baseline)
- DY5:
  - IT-12.3 Colorectal Cancer Screening
    - Our goal is increase the % of patients that have received a Colorectal Cancer screening to at least 27.8% (or minimum improvement of 3.8% total over baseline)

As we establish the Baylor Clinic on the Baylor Medical Center at Carrollton campus, we will aim to work with both primary care and specialty care physicians to become integrated parts of the care team. We hope in DY4 and DY5 these physicians will work together in order to meet these improvement targets around colorectal screening, prevention and education. We feel that Gastroenterologists should handle more complex cases but also use this opportunity to help educate underserved women about the importance of screenings and prevention.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Metrics selected were based on historical data from similar programs with specialty care providers that showed material improvement in a 2-3 year time period.

Our metrics and milestones are designed to increase improvement in Colorectal Cancer screenings for the target population in Carrollton and are based off historical performance of a similar Baylor Clinic. Actual performance and improvement will not be determined until DY4, when the clinic is operational.

In Denton County the incidence rate of colorectal cancer is 40.0 cases per 100,000. It is the second leading cause of cancer related deaths in the US and as many as 60% of the deaths from

colorectal cancer could be avoided with regular screening tests.[401] There is a definite need for these services in Denton County and the Baylor Clinic plans to provide these screenings to a greater number of people. There is greater need for patients to receive (appropriate) sigmoidoscopies/ colonoscopies in the region as a preventive measure. According to the Centers for Disease Control and Prevention, Hispanics and African Americans are less likely to get screened for colorectal cancer and it is often found in the latter stages of the disease as compared to their Caucasian counterparts.[402] There is an opportunity to increase the colorectal cancer screening rates by engaging specialists in the Denton County area to provide these basic and advanced screenings along with education that is focused on this particular topic.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

For this particular project, we also accounted for the fact that Category 3 outcomes will not begin until DY4 and because this clinic will be a new endeavor, the clinical impact may not be fully realized until beyond DY5.

Related Category 1 and/or 2 projects

195018001.1.2- Improve Access to Specialty Care-Expand Specialty Care Services

[401] Healthy People North Texas: http://www.healthyntexas.org
[402] Centers for Disease Control and Prevention: http://www.cdc.gov/

195018001.3.7	*3.IT-12.3*	*Colorectal Cancer Screening*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.1.2*- Improve Access to Specialty Care-Expand Specialty Care Services		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in* ***DY4.*** *Historic data of similar Baylor Clinics show a baseline of 20% colorectal cancer screening rate (estimated baseline) during the starting years of a similar clinic's operations* ***Target Population:*** *Underserved/uninsured adults between the ages of 50-75 in Denton County (Carrollton).*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 4,288	**Process Milestone 2** [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete all plans Data Source: Documentation of planning reports Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 2,485 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Ensure that Clinic is in the E.H.R and able to track data Data Source: Documentation of system readiness Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 2,485	**Outcome Improvement Target 1** [IT-12.2]: Colorectal Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 24.0% (or a minimum of 1.9% improvement over baseline) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 7,975	**Outcome Improvement Target 2** [IT-12.2]: Colorectal Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 27.8% (or a minimum of 3.8% improvement over baseline) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 19,071

195018001.3.7	*3.IT-12.3*	*Colorectal Cancer Screening*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.1.2*- Improve Access to Specialty Care-Expand Specialty Care Services		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in* ***DY4.*** *Historic data of similar Baylor Clinics show a baseline of 20% colorectal cancer screening rate (estimated baseline) during the starting years of a similar clinic's operations* ***Target Population:*** *Underserved/uninsured adults between the ages of 50-75 in Denton County (Carrollton).*		
Year 2 (10/1/2012 – 9/30/2013)	**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: $4,288	Year 3 Estimated Outcome Amount: $ 4,970	Year 4 Estimated Outcome Amount: $ 7,975	Year 5 Estimated Outcome Amount: $ 19,071
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 36,304			

Title of Outcome Measure (Improvement Target): Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure)

Unique RHP Outcome Identification Number: 195018001.3.8

Performing Provider Name/TPI: Trinity MC, LLC d/b/a Baylor Medical Center of Carrollton/195018001

Outcome Measure Description

IT-1.10 Diabetes care: *HbA1c poor control (>9.0%) (Standalone measure)*

- Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

The Baylor Clinic on the Baylor Medical Center at Carrollton is planned to be operational by DY4. While we expect some clinical improvement in patients who will enroll in the chronic disease management program, we will not know the potential of this until patients are seen in the clinic and enrolled in the program for at least 6 months. We have based our HbA1c projections on a similar Baylor Clinic on another campus. We may need to modify these metrics and outcomes once the clinic is operational in DY4.

By the end of the waiver, our goal is to have < 22.6% (or minimum of 1.2% improvement over established baseline) of patients 18-75 years old with diabetes (type 1 or type 2) out of glycemic control (HbA1c >9.0%). This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program. The additional qualifiers for this metric are the following: 1) a patient has been engaged in chronic care management for at least 6 months, 2) Two HbA1c measures will be taken per patient and the most recent HbA1c score will be used for reporting. Improvement targets may look low. This is due to: 1) establishment of a new clinic with no historical data and 2) uncertainty around disease severity of Carrollton patients.

One of the outcome measures we have chosen for our chronic care management program is HbA1c performance, as determined by a reduction in poor control, defined as the percent of the population with HbA1c > 9.0%.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will engage in project planning- we will engage stakeholders, identify current capacity and needed resources. We will determine timelines and document implementation plans
- DY3:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-3: Develop and Test Data Systems
        - We will continue to engage in project planning and operationalize the clinic through hiring staff, securing capital expenditures, setting up data collection processes, etc.

Outcome Improvement Targets for each year

- DY4:
    - IT-1.10: Diabetes Care: HbA1c poor control (> 9.0%)
        - Our goal is to reduce the HbA1c > 9.0% rate to ≤ 23.8% (or minimum improvement of 0.6% over established baseline)
- DY5:
    - IT-1.10: Diabetes Care: HbA1c poor control (> 9.0%)
        - Our end goal is to the HbA1c > 9.0% rate to ≤ 22.6% (or minimum improvement of 1.2% over established baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

Our metrics and milestones are designed to increase improvement in chronic disease management participation for the target population in Carrollton and are based off historical performance of a similar Baylor Clinic. Actual performance and improvement will not be determined until DY4, when the clinic is operational.

In Dallas County, more than 11.4% of the population has a diagnosis of Diabetes.[403] This equates to 78,000 people in Denton County.[404] Traditionally, the underserved population does not have access to the necessary medications and supplies to manage their diabetes thus many patients go undiagnosed or have poor glucose control. Lack of proper education coupled with a lack of primary care attention often leads to more severe complications and poor health outcomes for those with diabetes. This project would facilitate timely and appropriate care for those with diabetes and ensure that regular labs and point of care testing is completed to monitor results and make appropriate interventions.

Bodenheimer, et. al, found that patient self-management of chronic disease conditions, such as diabetes, that was co-located in a primary care setting led to significant improvement in HbA1c control in patients.[405] A recent of edition of Managed Care found that patients with an HbA1c > 9 had on average almost $5000 worth of hospitalization costs, while those with an HbA1c of < 7 had about $2700 in hospitalization costs[406]. Focusing efforts on improving glycemic control should result in reduced co-morbid conditions and improved complication rates for these patients. We expect that at least 5-7% of patients that are seen regularly in a Baylor Clinic will have improved HbA1c levels.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

[403] RHP 9 Community Health Needs Assessment
[404] Healthy People North Texas: http://www.healthyntexas.org
[405] Bodenheimer, T., Lorig, K.., Holman, H., Grumbach, K. Patient Self-management of Chronic Disease in Primary Care *JAMA* (May 15, 2008).
[406] MenzinJ, Korn, J, Cohen, J, et.al Relationship between glycemic control and diabetes related hospital costs in patients with type 1 or type 1 diabetes mellitus. J Manag Care Pharm. 2010; 16(4):264-275.

For this particular project, we also accounted for the fact that Category 3 outcomes will not begin until DY4 and because this clinic will be a new endeavor, the clinical impact may not be fully realized until beyond DY5.

Related Category 1 and/or 2 projects

195018001.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

195018001.3.8	*3.IT-1.10*	*Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure)*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY4. Historic data of similar Baylor Clinics show a baseline of 25% of patients have an HbA1c > 9.0% during preliminary years of operation.* ***Target Population:*** *Uninsured/undeserved patients in Denton County (Carrollton) with an HbA1c > 9.0%*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
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 reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 4,020	**Process Milestone 2** [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete all plans Data Source: Documentation of planning reports Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 1,812 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Ensure that Clinic is in the E.H.R and able to track data Data Source: Documentation of system readiness Process Milestone 3 Estimated Incentive Payment *(maximum*	**Outcome Improvement Target 1** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure) Improvement Target: ≤23.8% (or minimum of 0.6% improvement over baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment: $ 5,815	**Outcome Improvement Target 3** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure) Improvement Target: ≤22.6% (or minimum 1.2% improvement over baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 13,906

195018001.3.8	*3.IT-1.10*	*Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure)*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY4. Historic data of similar Baylor Clinics show a baseline of 25% of patients have an HbA1c > 9.0% during preliminary years of operation.* ***Target Population:*** *Uninsured/undeserved patients in Denton County (Carrollton) with an HbA1c > 9.0%*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	amount): $ 1,812		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):$ 4,020	Year 3 Estimated Outcome Amount: $ 3,624	Year 4 Estimated Outcome Amount: $ 5,815	Year 5 Estimated Outcome Amount: $ 13,906
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 27,365			

Title of Outcome Measure (Improvement Target): IT-1.11 Diabetes Care: BP control (<140/80 mmHg) NQF 0061 (Standalone measure)

Unique RHP Outcome Identification Number: 195018001.3.9

Performing Provider Name/TPI: Trinity MC, LLC d/b/a Baylor Medical Center of Carrollton/195018001

Outcome Measure Description

IT-1.11 Diabetes care: *BP control (<140/80mm Hg)- (Standalone measure)*

- Numerator: Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg.
- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

The Baylor Clinic on the Baylor Medical Center at Carrollton is planned to be operational by DY4. While we expect some clinical improvement in patients who will enroll in the chronic disease management program, we will not know the potential of this until patients are seen in the clinic and enrolled in the program for at least 6 months. We have based our BP control projections on a similar Baylor Clinic on another campus. We may need to modify these metrics and outcomes once the clinic is operational in DY4.

By the end of the waiver, our goal is to have > 55.7% (or minimum of 2.3% improvement over baseline) of patients 18-75 years old with diabetes (type 1 or type 2) under BP control (< 140/80 mmHg). This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program for at least 6 months. Improvement targets may look low. This is due to: 1) establishment of a new clinic with no historical data and 2) uncertainty around disease severity of Carrollton patients.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will engage in project planning- we will engage stakeholders, identify current capacity and needed resources. We will determine timelines and document implementation plans

- DY3:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-3: Develop and Test Data Systems
        - We will continue to engage in project planning and operationalize the clinic through hiring staff, securing capital expenditures, setting up data collection processes, etc.

Outcome Improvement Targets for each year

- DY4:
    - Diabetes Care: BP control (<140/80 mmHg)
        - Our goal is increase the % of patients in good BP control (<140/80 mmHg) to 53.4% (or minimum of 1.2% improvement over baseline) of patients at the Baylor Clinic who have engaged in the chronic care management program
- DY5:
    - Diabetes Care: BP control (<140/80 mmHg)
        - Our goal is increase the % of patients in good BP control (<140/80 mmHg) to 55.7% (or minimum of 2.3% improvement over baseline) of patients at the Baylor Clinic who have engaged in the chronic care management program

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

Our metrics and milestones are designed to increase improvement in chronic disease management participation for the target population in Carrollton and are based off historical performance of a similar Baylor Clinic. Actual performance and improvement will not be determined until DY4, when the clinic is operational. We have historically tracked BP control as < 130/80 mmHg and will modify this as we build the data tracking systems for Baylor Carrollton.

As part of the standard of care for diabetes management, optimal blood pressure control is an included component of this protocol. At Baylor Health Care System, blood pressure control and management is a required part of the diabetes care bundle in order to avoid other co-morbid conditions such as heart disease and stroke. A 2010 study in the New England Journal of Medicine by Cushman, et. al showed that better and less severe health outcomes related to cardiovascular episodes and stroke were achieved with tight blood pressure control in diabetic

patients[407]. Events that would be fatal with higher blood pressure became nonfatal under better blood pressure control in these studies completed. As part of an outpatient, clinic based protocol, blood pressure control can be achieved in patients who will come to the Baylor Clinic as part of the primary care expansion project.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

For this particular project, we also accounted for the fact that Category 3 outcomes will not begin until DY4 and because this clinic will be a new endeavor, the clinical impact may not be fully realized until beyond DY5.

Related Category 1 and/or 2 projects

195018001.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

[407] Cushman WC, Evans, GW, et. al Effects of intensive blood pressure control in type 2 diabetes mellitus. N Engl J Med. 2010. Apr 29; 362(17): 1575-85

195018001.3.9	*3.IT-1.11*	*Diabetes Care: BP control (<140/80 mmHg)*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY4. Historic data of similar Baylor Clinics show a baseline of 50.9% of patients have a BP < 130/80 mmHg during preliminary years of operation.* ***Target Population:*** *Underserved/uninsured diabetic patients with BP >140/80 mmHg in Denton County (Carrollton)*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 1,005	**Process Milestone 2** [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete all plans Data Source: Documentation of planning reports Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 1,812 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Ensure that Clinic is in the E.H.R and able to track data Data Source: Documentation of system readiness Process Milestone 3 Estimated Incentive Payment *(maximum*	**Outcome Improvement Target 1** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Standalone measure) Improvement Target: > 53.4% (or minimum of 1.2% improvement over baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 5,815	**Outcome Improvement Target 2** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Standalone measure) Improvement Target: > 55.7% (or minimum of 2.3% improvement over baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 13,906

195018001.3.9	*3.IT-1.11*	*Diabetes Care: BP control (<140/80 mmHg)*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY4. Historic data of similar Baylor Clinics show a baseline of 50.9% of patients have a BP < 130/80 mmHg during preliminary years of operation.* ***Target Population:*** *Underserved/uninsured diabetic patients with BP >140/80 mmHg in Denton County (Carrollton)*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	amount): $ 1,812		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 1,005	Year 3 Estimated Outcome Amount: $ 3,624	Year 4 Estimated Outcome Amount: $ 5,815	Year 5 Estimated Outcome Amount: $ 13,906
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 24,350			

Title of Outcome Measure (Improvement Target): IT-1.13 - Diabetes Care: Diabetes care: Foot exam- NQF 0056

Unique RHP Outcome Identification Number: 195018001.3.10

Performing Provider Name/TPI: Trinity MC, LLC d/b/a Baylor Medical Center of Carrollton/195018001

Outcome Measure Description

IT-1.13 Diabetes care *Foot exam- (Non- standalone measure)*

- 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).
-

The Baylor Clinic on the Baylor Medical Center at Carrollton is planned to be operational by DY4. While we expect some clinical improvement in patients who will enroll in the chronic disease management program, we will not know the potential of this until patients are seen in the clinic and enrolled in the program for at least 6 months. We have based our foot examination projections on a similar Baylor Clinic on another campus. We may need to modify these metrics and outcomes once the clinic is operational in DY4.

By the end of the waiver, our goal is to have > 96.8% (or a minimum of 1.8% improvement over baseline) of patients 18-75 years old with diabetes (type 1 or type 2) receive a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year(s). This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program. Improvement targets may look low. This is due to: 1) establishment of a new clinic with no historical data and 2) uncertainty around disease severity of Carrollton patients.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

        - We will engage in project planning- we will engage stakeholders, identify current capacity and needed resources. We will determine timelines and document implementation plans

- DY3:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-3: Develop and Test Data Systems
        - We will continue to engage in project planning and operationalize the clinic through hiring staff, securing capital expenditures, setting up data collection processes, etc.

Outcome Improvement Targets for each year

- DY4
    - IT-1.13: Diabetes Care: Foot exam
        - Our goal is to increase this rate to at least 96.4% of diabetic patients receiving a foot exam (or a minimum of 1% improvement over baseline)
- DY5:
    - IT-1.13: Diabetes Care: Foot exam
        - Our goal is to increase this rate to at least 96.8% of diabetic patients receiving a foot exam (or a minimum of 1.8% improvement over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

Our metrics and milestones are designed to increase improvement in chronic disease management participation for the target population in Carrollton and are based off historical performance of a similar Baylor Clinic. Actual performance and improvement will not be determined until DY4, when the clinic is operational.

An innovative part of this project is that the educators (CHWs and RN Care Managers) will be able to conduct diabetic foot exams as part of their education session with their patients. This will increase the rate of screening and allow these providers to identify issues such as ulcers and nerve issues earlier and more often. Foot exams are a low cost, highly effective way to avoid costly interventions such as wound care and management, amputations, neuropathy and

other complex issues. This is better utilization and management of resources through early identification and prevention of serious diabetes foot related issues. It is recommended by the American Diabetes Association that diabetic patients receive yearly foot exams to determine if there are predisposing factors for ulceration and amputation.[408]

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.
For this particular project, we also accounted for the fact that Category 3 outcomes will not begin until DY4 and because this clinic will be a new endeavor, the clinical impact may not be fully realized until beyond DY5.

Related Category 1 and/or 2 projects
195018001.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

[408] American Diabetes Association: http://www.ada.org

95018001.3.10	*3.IT-1.13*	*Diabetes Care: Foot Exam*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY4. Historic data of similar Baylor Clinics show a baseline of 96.1% of patients have diabetic foot exam during preliminary years of operation.* ***Target Population:*** *Underserved/uninsured patients with diabetes in Dallas County*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 2,010	**Process Milestone 2** [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete all plans Data Source: Documentation of planning reports Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 453 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Ensure that Clinic is in the E.H.R and able to track data Data Source: Documentation of system readiness Process Milestone 3 Estimated	**Outcome Improvement Target 1** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Standalone measure) Improvement Target: >96.4% (or a minimum of 1% improvement over baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 1,454	**Outcome Improvement Target 2** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Standalone measure) Improvement Target: >96.8% (or a minimum of 1.8% improvement over baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 3,476

95018001.3.10	*3.IT-1.13*	*Diabetes Care: Foot Exam*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY4. Historic data of similar Baylor Clinics show a baseline of 96.1% of patients have diabetic foot exam during preliminary years of operation.* ***Target Population:*** *Underserved/uninsured patients with diabetes in Dallas County*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Incentive Payment *(maximum amount):* $ 453		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 2,010	Year 3 Estimated Outcome Amount: $ 906	Year 4 Estimated Outcome Amount: $ 1,454	Year 5 Estimated Outcome Amount: $ 3,476
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 7,846			

Title of Outcome Measure (Improvement Target): IT-11.1 Improvement in Clinical Indicator in identified disparity group: Improvement in Asthma Percent of Opportunities Achieved

Unique RHP Outcome Identification Number: 195018001.3.11

Performing Provider Name/TPI: Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton/ 195018001

Outcome Measure Description

The disparity group for this metric is the underserved/uninsured population in Denton County that has uncontrolled Asthma.

IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider *(Standalone measure)*

- Numerator: Number of asthma opportunities completed/fulfilled
- Denominator: Asthma appropriate opportunities x number of asthma patients

By the end of the waiver, our goal is to have achieved a 30.0% (or 10% improvement over baseline) percent of opportunities achieved for the Baylor Health Care System Asthma Percent of Opportunity Achieved (POA).

At Baylor Health Care System, we have a standard Asthma POA which consists of: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. We measure this yearly for our Asthma patients and calculate POA by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population.

POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in asthma management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their asthma patients than in the prior reporting period.

For an illustrative example: For Asthma- there are 4 potential opportunities (i.e. metrics) per patient (1) documentation of Action/Mgmt Plan, 2) Severity Assessment, 3) Controller Therapy

for those who are eligible, and 4) Spirometry within last two years). The denominator would be # of patients x 4. So, for example, if there are 10 patients x 4 opportunities each = 40 opportunities to be achieved. If, in the course of the year, only 30 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 30/40=75%. To achieve a 10% improvement in POA, we would have to have completed at least 34/40 opportunities to get at 85% achievement.

We do not have a baseline for these metrics and have relied on historical performance and improvement opportunities of other Baylor Clinics on other Baylor campuses in their preliminary years of operations to shape our outcomes.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will engage in project planning- we will engage stakeholders, identify current capacity and needed resources. We will determine timelines and document implementation plans
- DY3:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-3: Develop and Test Data Systems
        - We will continue to engage in project planning and operationalize the clinic through hiring staff, securing capital expenditures, setting up data collection processes, etc.

Outcome Improvement Targets for each year

- DY4:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Asthma Percent of Opportunities Achieved)
        - Our goal is to increase the POA % for Asthma patients to 25% (or 5% improvement over baseline)
- DY5:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Asthma Percent of Opportunities Achieved)
        - Our goal is to increase the POA % for Asthma patients to 30% (or 10% total improvement over baseline)

In order to meet these improvements, primary care and specialists in the community will have to work together to meet these goals. We feel that Pulmonologists should handle more complex cases but also use this opportunity to help educate the underserved population (especially Hispanics and African Americans) about the importance of screenings and prevention.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Metrics selected were based on historical data from similar programs with specialty care providers that showed material improvement in a 2-3 year time period.

We plan on measuring the improvement in Asthma for Baylor Clinic patients. At Baylor Health Care System, we have a standard Asthma Percent of Opportunities Achieved which consists of: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. We feel that this measure is a comprehensive way to measure the patients with Asthma in the Baylor Clinic and manage their condition holistically.

Asthma affects about 19.6% of the Dallas County population and had approximately 1158 cases of hospitalization in 2010.[409] According to the Office of Minority Health, African Americans were 30% more likely to have Asthma than non-Hispanic whites and were three times more likely to die from an Asthma related issue than non-Hispanic whites. Hispanics are 30% more likely to visit the hospital for Asthma than non-Hispanic whites.[410]

A study by Meng, Leung, et. al found that patients with Asthma that saw a specialist had higher rates of compliance because specialists were more likely to identify the disease and follow national guidelines and protocols to treat these patients leading to better quality outcomes and long(er) term control[411]. Making the pulmonologist a part of our Asthma patients' care team will help to avoid exacerbations, prevent complications and reduce hospitalizations.

Many of the underserved patients in the region require specialty care related to chronic diseases. Lack of timely access to needed care often results in clinical exacerbations and worsening of their health conditions. This can be avoided or lessened through improved access. A study conducted in 2010 by Bellinger, et al. confirmed that minority and underserved

[409] Healthy People North Texas: http://www.healthyntexas.org

[410] Office of Minority Health: http://www.minorityhealth.hhs.gov

[411] Meng YY, Leung KM, Berkbigler D, Halbert RJ. Compliance with US asthma management guidelines and specialty care: a regional variation or national concern? J Eval Clin Pract. 1999 May;5(2):213-21.

populations not only receive less care but access to care is mitigated by physician referral, geographic location and insurance type.[412]

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

195018001.1.2- Improve Access to Specialty Care-Expand Specialty Care Services

[412] Bellinger, JD, Hassan, RM, et.al. Specialty care use in US patients with chronic diseases. Int J. Envion. Res Public Health 2010, 7, 975-990.

195018001.3.11	*3.IT-11.1*	*Improvement in Clinical Indicator in identified disparity group-Asthma management in underserved/uninsured population*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.1.2- Improve Access to Specialty Care-Expand Specialty Care Services*		
Starting Point/Baseline:	***Definition of Metric:*** *Percent of Opportunities Achieved for Asthma patients = Number of opportunities (metrics) fulfilled divided by the number of opportunities appropriate per patient x number of patients* ***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year but similar Baylor clinics have rates in the 20-30% range* ***Target Population:*** *Underserved/uninsured patients in Denton County with uncontrolled Asthma*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $4,288	**Process Milestone 2** [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete all plans Data Source: Documentation of planning reports Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 2,485 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Ensure that Clinic is in the E.H.R and able to track data Data Source: Documentation of system readiness	**Outcome Improvement Target 1** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 25.0% (or 5% improvement over baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $7,974	**Outcome Improvement Target 2** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 30.0% (or 10% improvement over baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $19,072

195018001.3.11	*3.IT-11.1*	*Improvement in Clinical Indicator in identified disparity group-Asthma management in underserved/uninsured population*	
Trinity MC, LLC d/b/a Baylor Medical Center at Carrollton			*195018001*
Related Category 1 or 2 Projects:	*195018001.1.2- Improve Access to Specialty Care-Expand Specialty Care Services*		
Starting Point/Baseline:	***Definition of Metric:*** *Percent of Opportunities Achieved for Asthma patients = Number of opportunities (metrics) fulfilled divided by the number of opportunities appropriate per patient x number of patients* ***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year but similar Baylor clinics have rates in the 20-30% range* ***Target Population:*** *Underserved/uninsured patients in Denton County with uncontrolled Asthma*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 2,485		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $4,288	Year 3 Estimated Outcome Amount: $4,970	Year 4 Estimated Outcome Amount: $ 7,974	Year 5 Estimated Outcome Amount: $19,072
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 36,304			

Title of Outcome Measure (Improvement Target): IT-1.7 Controlling High Blood Pressure (NCQA-HEDIS, 2012,NQF 0018) **(Standalone)**

Unique RHP Outcome Identification Number: 121790303.3.1

Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description

IT-1.7: Controlling high blood pressure *(Standalone measure)*

- Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year
- Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension

As one of our primary care metrics we chose blood pressure. As high blood pressure is a prerequisite to many other chronic illnesses and serious medical conditions, getting BP under control with proper PCP supervision, medications and regular visits can help patients' quality of life and overall health.

By the end of the waiver, our goal is to have > 54.8% (or a total of 7.5% improvement over baseline)of patients who are patients of the Baylor Clinics at Baylor Medical Center at Garland to have good blood pressure control (< 140/80 mmHg). This is an improvement of 7.5% over baseline. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
        - We will confirm and establish our baseline. Baylor currently tracks BP control and uses a threshold of <130/80 mmHg for patients that have hypertension. Based on our current data, 47.3% of patients with hypertension have controlled BP (130/80 mmHg)

Improvement Milestones

- DY3:
  - IT-1.7: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)
    - Our goal is increase the % of patients that have BP control (140/80 mmHg) to 49.9% (or 2.6% improvement over established baseline)
- DY4:
  - IT-1.7: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone). Our goal is increase the % of patients that have BP control (140/80 mmHg) to 52.4% (or 5.1% improvement over established baseline)
- DY5:
  - IT-1.7: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone). Our goal is increase the % of patients that have BP control (140/80 mmHg) to 54.8% (or 7.5% improvement over established baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Controlling high blood pressure is essential in avoiding heart attacks, stroke, heart failure and a multitude of other diseases and complications. Through medication management, proper primary care attention and education, patients can achieve better blood pressure control in the outpatient setting. In Region 9, Hypertension was identified as one of the top 5 most prevalent diseases in the area for ED visits.[413] A recent article in the New York Times suggested that hypertensive complications can be especially deadly in the African American population, who make up 22.5% of the RHP 9 population[414] and 14.5% of the Garland population.[415] Blood pressure is a standard metric that all Baylor Clinics monitor and regulate. Patients who are uncontrolled will receive the attention they need to get their hypertension under control. Patients will receive medication management, lifestyle management techniques and education

[413] RHP 9 Community Health Needs Assessment
[414] http://health.nytimes.com/health/guides/disease/hypertension/complications.html
[415] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/4829000.html

about their illness in this clinic PCMH setting. Our metrics and milestones are designed to increase improvement in BP control for the target population.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

121790303.3.1	*3.IT-1.7*	*Controlling high blood pressure*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.1.1- Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Garland had 47.3% of patients with controlled BP (130/80 mmHg)* ***Target Population:*** *Underserved/uninsured patients in Garland with uncontrolled BP (>140/80 mmHg)*		
Year 2 (10/1/2012 – 9/30/2013)	**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-1.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 9,029 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $9,029	**Outcome Improvement Target 1** [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone) Improvement Target: > 49.9% (or 2.6% improvement over baseline) of patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $20,932	**Outcome Improvement Target 2** [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone) Improvement Target: > 52.4% (or 5.1% improvement over baseline) of patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $33,588	**Outcome Improvement Target 3** [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone) Improvement Target: > 54.8% (or 7.5% improvement over baseline) of patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $80,319
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $18,058	Year 3 Estimated Outcome Amount: $20,932	Year 4 Estimated Outcome Amount: $33,588	Year 5 Estimated Outcome Amount: $80,319
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $152,897			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores (**Standalone measure)**

1) Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Clinic Wait Times

Unique RHP Outcome Identification Number: 121790303.3.2

Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description

IT-6.1: 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. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(1) are getting timely care, appointments, and information; *(Standalone measure)*
(2) how well their doctors communicate; *(Standalone measure)*
(3) patient's rating of doctor access to specialist; *(Standalone measure)*
(4) patient's involvement in shared decision making, and *(Standalone measure)*
(5) patient's overall health status/functional status. *(Standalone measure)*

Patient satisfaction is an important part of overall treatment and encourages participation and compliance of patients' in their own care. For this metric we will be measuring is to improve the satisfaction scores in regards to clinic wait times. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic

By the end of the waiver, our goal is to have the patients at Baylor Clinics on the Baylor Medical Center at Garland campus to attain a patient satisfaction score of 88.7% on the survey question related to wait time to appointment satisfaction. This falls under metric (1)- patients are getting timely care, appointments and information of 3.6.1, option (1). Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Although the Baylor Clinic at Baylor Medical Center at Garland is at a 86th percentile score of patients satisfaction related to this particular metric, we believe there is still opportunity to improve and that with any incremental gain in patient satisfaction equates to better compliance and outcomes for our patients. The baseline percentile score of 86.8% is equivalent to a 72 percentile score nationally, which also presents an opportunity to improve for this Baylor Clinic. By maintaining high standards and enforcing metrics around satisfaction for our staff, we will continue to pursue high patient satisfaction scores in our Baylor Clinics.

Process Milestones:

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - We will confirm and establish our baseline. Currently, the Baylor Clinics at Baylor Medical Center at Garland are at 86.8% satisfaction with clinic wait times

Improvement Milestones:

- DY3:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - Our goal is increase the % of patient satisfaction related to wait times to 87.5% (or 0.7% improvement over baseline)
- DY4:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - Our goal is increase the % of patient satisfaction related to wait times to 88.1% (or1.3% improvement over baseline)
- DY5:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - Our goal is increase the % of patient satisfaction related to wait times to 88.7% (or 1.9% improvement over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Data from Press Ganey Associates in 2007 has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease[416]. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less physician/staff time, reducing length of visits and wait times for the overall practice. Baylor Clinics have historically had high performance in all measures related to patient satisfaction; however there is opportunity for improvement. This outcome has an

[416] Drain, M., & Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

impact on the region through increasing utilization of outpatient based primary care. If patients are satisfied, they will continue to come to their appointments, stay healthier and stay out of the ED. We anticipate that we will be able to raise patient satisfaction in the domains mentioned below through the Baylor Clinic PCMH model.

1) Patients are getting timely care, appointments and information (Standalone measure): We will measure this particular metric through monitoring and improving the survey question around improving clinic wait times for patients

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

121790303.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.1.1-*. Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Garland had a satisfaction rate related to clinic wait times of 86.8%* ***Target Population:*** *Underserved/uninsured patients in a Baylor Clinic PCMH in Garland*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 6,772	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 87.5% (or 0.7% improvement over baseline) satisfaction rate with clinic wait times will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 7,849	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 88.1% (or 1.3% improvement over baseline) satisfaction with clinic wait times will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 12,595	**Outcome Improvement Target 3** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 88.7% (or 1.9% improvement over baseline) satisfaction with clinic wait times will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 30,120
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 6,772	Year 3 Estimated Outcome Amount: $ 7,849	Year 4 Estimated Outcome Amount: $ 12,595	Year 5 Estimated Outcome Amount: $ 30,120
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 57,336			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores (**Standalone measure)**

2) Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Response Time to Patient Phone Calls

Unique RHP Outcome Identification Number : 121790303.3.3

Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description

IT-6.1: 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. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(1) are getting timely care, appointments, and information; *(Standalone measure)*
(2) how well their doctors communicate; ***(Standalone measure)***
(3) patient's rating of doctor access to specialist; *(Standalone measure)*
(4) patient's involvement in shared decision making, and *(Standalone measure)*
(5) patient's overall health status/functional status. *(Standalone measure)*

Patient satisfaction is an important part of overall treatment and encourages participation and compliance of patients' in their own care. For this metric we will be measuring improvement in the responsiveness to patient phone calls in a timely manner.

By the end of the waiver, our goal is to have the Baylor Clinic at Baylor Medical Center at Garland obtain a patient satisfaction score of 91.7% on the survey question related to patient phone calls being returned in a timely fashion. This falls under metric (2) Patients are getting timely care, appointments and information of 3.6.1, option (2). Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Although the Baylor Clinic at Baylor Medical Center at Garland is at a 90th percentile score of patients satisfaction related to this particular metric, we believe there is still opportunity to improve and that with any incremental gain in patient satisfaction equates to better compliance and outcomes for our patients. The baseline percentile score of 90.3% is equivalent to a 83 percentile score nationally, which also presents an opportunity to improve for this Baylor Clinic. By maintaining high standards and enforcing metrics around satisfaction for our staff, we will continue to pursue high patient satisfaction scores in our Baylor Clinics.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will confirm and establish our baseline. Currently, the Baylor Clinics at Baylor Medical Center at Garland are at 90.3% satisfaction with patients receiving a response to their phone calls in a timely manner

Improvement Milestones

- DY3:
    - IT-6.1: Percent improvement of patient satisfaction scores
        - Our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 90.8% (or minimum of 0.5% improvement over baseline)
- DY4:
    - IT-6.1: Percent improvement of patient satisfaction scores
        - Our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 91.3% (or minimum of 1% improvement over baseline)
- DY5:
    - IT-6.1: Percent improvement of patient satisfaction scores
        - Our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 91.7% (or minimum of 1.4% improvement over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Data from Press Ganey Associates in 2007 has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their

disease[417]. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less physician/staff time, reducing length of visits and wait times for the overall practice. Baylor Clinics have historically had high performance in all measures related to patient satisfaction; however there is opportunity for improvement. This outcome has an impact on the region through increasing utilization of outpatient based primary care. If patients are satisfied, they will continue to come to their appointments, stay healthier and stay out of the ED. We anticipate that we will be able to raise patient satisfaction in the domains mentioned below through the Baylor Clinic PCMH model.

2) Patients are getting timely care, appointments and information (Standalone measure): We will measure this particular metric through monitoring and improving the survey question around response times to patient phone calls

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

[417] Drain, M., & Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

121790303.3.3	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.1.1-Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Garland had a satisfaction rate related to clinic response to patient phone call of 90.3%* ***Target Population:*** *Underserved/uninsured PCMH patients of the Baylor Clinic in the Garland area*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 6,772	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 90.8% (or 0.5% improvement over baseline) satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 7,849	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 91.3% (or 1% improvement over baseline) satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 12,595	**Outcome Improvement Target 3** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 91.7% (or 1.4% improvement over baseline) satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 30,120
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 6,772	Year 3 Estimated Outcome Amount: $ 7,849	Year 4 Estimated Outcome Amount: $ 12,595	Year 5 Estimated Outcome Amount: $ 30,120
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 57,336			

Title of Outcome Measure (Improvement Target): IT-12.1 Breast Cancer Screening (Non-Standalone)

Unique RHP Outcome Identification Number: 121790303.3.4

Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description

IT-12.1: Breast Cancer Screening (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

By the end of the waiver, our goal is to have > 46.7% of women ages 40-69 (or 8.9% improvement over baseline) who are patients of the Baylor Clinics at Baylor Medical Center at Garland to have a breast cancer screening. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones:

DY2:

[P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

We will confirm and establish our baseline. The Baylor Clinic at Baylor Medical Center at Garland is at a 37.8% screening rate for women between 40-69 years old

Improvement Milestones

DY3:

[IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone)

Our goal is increase the % of patients have had a breast cancer screen to at least 40.9% (or 3.1% improvement over baseline)

DY4:

[IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone)

Our goal is increase the % of patients have had a breast cancer screen to at least 43.9% (or 6.1% improvement over baseline)

DY5:

[IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone)

Our goal is increase the % of patients have had a breast cancer screen to at least 46.7% (or 8.9% improvement over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

In Dallas County, 23.7/100,000 women die from breast cancer, with a higher rate of 37/100,000 for African American women.[418] According to the Healthy North Texas community dashboard, 76.1% of women in the Dallas-Plano-Irving areas received a mammogram, leaving opportunities to increase this rate for the underserved population. There is room for improvement with this metric to screen more women and utilize early detection methods for breast cancer.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

[418] Healthy People North Texas: http://www.healthyntexas.org

121790303.3.4	*3.IT-12.1*	*Breast Cancer Screening*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.1.1.-Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Garland had only 37.8% of women over the age of 40 receive a breast cancer screen* ***Target Population:*** *Underserved women in Dallas County (Garland) that are over the age of 40*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 11,286	**Outcome Improvement Target 1** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone) Improvement Target: > 40.9% (or 3.1% improvement over baseline) of women over the age of 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 13,082	**Outcome Improvement Target 2** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone) Improvement Target: > 43.9% (or 6.1% improvement over baseline) of women over the age of 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 20,992	**Outcome Improvement Target 3** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone) Improvement Target: > 46.7% (or 8.9% improvement over baseline) of women over the age of 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 50,199
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 11,286	Year 3 Estimated Outcome Amount: $ 13,082	Year 4 Estimated Outcome Amount: $ 20,992	Year 5 Estimated Outcome Amount: $ 50,199
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 95,559			

Title of Outcome Measure (Improvement Target): IT-12.5 Other USPSTF-endorsed screening outcome measures (Non-Standalone): Influenza Vaccination Rate

Unique RHP Outcome Identification Number: 121790303.3.5

Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description

IT-12.5: Other USPSTF-endorsed screening outcome measures

As part of primary care, the influenza vaccine is a simple, cost effective way for patients to protect themselves from the flue and other potential clinical exacerbations.

By the end of the waiver, our goal is to have > 66.6% (or 5.5% improvement over baseline) of patients of Baylor Clinic patients over the age of 18 receive an influenza vaccination. This is an improvement of 5.5% over baseline. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

DY2:

P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

We will confirm and establish our baseline. The Baylor Clinics at Baylor Medical Center at Garland are at a 61.1% rate for patients over the age of 18 that have received influenza vaccine in past 12 months

Improvement Milestones

DY3:

IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone)

Our goal is increase the % of patients >18 years old that have had an influenza vaccination in the past 12 months to 63.0% (or 1.9% improvement over baseline)

DY4:

IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone)

Our goal is increase the % of patients >18 years old that have had an influenza vaccination in the past 12 months to 64.9% (or 3.8% improvement

DY5:

IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone)

Our goal is increase the % of >18 years old that have had an influenza vaccination in the past 12 months to 66.6% (or 5.5% improvement over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

In Dallas County, only 65% of individuals over the age of 18 received an influenza vaccination in the past 12 months.[419] The rate of influenza vaccinations in the Region is quite low and there is an opportunity to increase the number in the target population that receive this basic vaccination in order to prevent exacerbations of health issues, reduce the prevalence of influenza and prevent ED visits related to influenza that can otherwise be handled in an outpatient setting.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

[419] Healthy People North Texas: http://www.healthyntexas.org

121790303.3.5	*IT-12.5*	*Other USPSTF-endorsed screening outcome measures (Influenza Vaccination)*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.1.1- Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Garland had 61.1% of patients over the age of 18 receive an influenza vaccination* ***Target Population:*** *Underserved/uninsured patients 18 years and older in Dallas County*		
Year 2 (10/1/2012 – 9/30/2013)	**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-1.1] Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete planning processes for primary care expansion Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 11,286	**Outcome Improvement Target 1** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone) Improvement Target: > 63.0% (or 1.9% improvement over baseline) of patients over the age of 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 13,082	**Outcome Improvement Target 2** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone) Improvement Target: > 64.9% (or 3.8% improvement over baseline) of patients over the age of 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 20,992	**Outcome Improvement Target 3** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone) Improvement Target: > 66.6% (or 5.5% improvement over baseline) of patients over the age of 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 50,199
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 11,286	Year 3 Estimated Outcome Amount: $ 13,082	Year 4 Estimated Outcome Amount: $ 20,992	Year 5 Estimated Outcome Amount: $ 50,199
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 95,559			

Title of Outcome Measure (Improvement Target): IT-11.1 Improvement in Clinical Indicator in identified disparity group: Improvement in Asthma Metrics

Unique RHP Outcome Identification Number: 121790303.3.6

Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description

IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider *(Standalone measure)*

- Numerator: Number of asthma opportunities completed/fulfilled
- Denominator: Asthma appropriate opportunities x number of asthma patients

The disparity group for this metric is the underserved/uninsured population in Dallas County that has uncontrolled Asthma.

By the end of the waiver, our goal is to have achieved a 76.9% (or 3.9% improvement over baseline) percent of opportunities achieved for the Baylor Health Care System Asthma Percent of Opportunity Achieved (POA. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

At Baylor Health Care System, we have a standard Asthma POA which consists of: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. We measure this yearly for our Asthma patients and calculate POA by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population.

POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in asthma management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their asthma patients than in the prior reporting period.

For an illustrative example: For Asthma- there are 4 opportunities (i.e. metrics) per patient (1) documentation of Action/Mgmt Plan, 2) Severity Assessment, 3) Controller Therapy for those who are eligible, and 4) Spirometry within last two years). The denominator would be # of patients x 4. So, for example, if there are 10 patients x 4 opportunities each = 40 opportunities to be achieved. If, in the course of the year, only 30 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 30/40=75%. To achieve a 10%

improvement in POA, we would have to have completed at least 34/40 opportunities to get at 85% achievement.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that 73% POA was achieved for Asthma patients

Improvement Milestones

- DY3:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Asthma Percent of Opportunities Achieved)
        - Our goal is to increase the POA % for Asthma patients to 74.4% (or 1.4% improvement over baseline)
- DY4:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Asthma Percent of Opportunities Achieved)
        - Our goal is to increase the POA % for Asthma patients to 75.6% (or 2.5% improvement over baseline)
- DY5:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Asthma Percent of Opportunities Achieved)
        - Our goal is to increase the POA % for Asthma patients to 76.9% (or 3.9% improvement over baseline)

In order to meet these improvements, primary care and specialists in the community will have to work together to meet these goals. We feel that Pulmonologists should handle more complex cases but also use this opportunity to help educate the underserved population (especially Hispanics and African Americans) about the importance of screenings and prevention.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Metrics selected were based on historical data from similar programs with specialty care providers that showed material improvement in a 2-3 year time period.

We plan on measuring the improvement in Asthma for Baylor Clinic patients. At Baylor Health Care System, we have a standard Asthma Percent of Opportunities Achieved which consists of: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. We feel that this measure is a comprehensive

way to measure the patients with Asthma in the Baylor Clinic and manage their condition holistically.

Asthma affects about 19.6% of the Dallas County population and had approximately 1158 cases of hospitalization in 2010.[420] According to the Office of Minority Health, African Americans were 30% more likely to have Asthma than non-Hispanic whites and were three times more likely to die from an Asthma related issue than non-Hispanic whites. African Americans make up 14.5 % of the Garland population.[421] Hispanics are 30% more likely to visit the hospital for Asthma than non-Hispanic whites.[422] Hispanics comprise 37.8% of the Garland population.[423]

A study by Meng, Leung, et. al found that patients with Asthma that saw a specialist had higher rates of compliance because specialists were more likely to identify the disease and follow national guidelines and protocols to treat these patients leading to better quality outcomes and long(er) term control[424]. Making the pulmonologist a part of our Asthma patients' care team will help to avoid exacerbations, prevent complications and reduce hospitalizations.

Many of the underserved patients in the region require specialty care related to chronic diseases. Lack of timely access to this needed care, often results in clinical exacerbations and worsening of their health conditions that can be avoided or lessened through improved access. A study conducted in 2010 by Bellinger, et. al confirmed that minority and underserved populations not only receive less care but access to care is mitigated by physician referral, geographic location and insurance type.[425]

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

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[420] Healthy People North Texas: http:///www.healthyntexas.org
[421] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/4829000.html
[422] Office of Minority Health: http://www.minorityhealth.hhs.gov
[423] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/4829000.html
[424] Meng YY, Leung KM, Berkbigler D, Halbert RJ. Compliance with US asthma management guidelines and specialty care: a regional variation or national concern? J Eval Clin Pract. 1999 May;5(2):213-21.
[425] Bellinger, JD, Hassan, RM, et.al. Specialty care use in US patients with chronic diseases. Int J. Envion. Res Public Health 2010, 7, 975-990.

Related Category 1 and/or 2 projects

121790303.1.2- Improve Access to Specialty Care-Expand Specialty Care Services

121790303.3.6	*3.IT-11.1*	*Improvement in Clinical Indicator in identified disparity group-Asthma management in underserved/uninsured population*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.1.2- Improve Access to Specialty Care-Expand Specialty Care Services*		
Starting Point/Baseline:	***Definition of Metric:*** Percent of Opportunities Achieved for Asthma patients = Number of opportunities (metrics) fulfilled divided by the number of opportunities appropriate per patient x number of patients ***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Garland Medical Center had achieved 73.0% of Asthma POA for their patients* ***Target Population:*** *Underserved/uninsured patients in Dallas County (Garland) with uncontrolled Asthma*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports/agreements with specialists Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 14,593	**Outcome Improvement Target 1** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 74.4% (or 1.4% improvement over baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 25,372	**Outcome Improvement Target 2** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 75.6% (or 2.5% improvement over baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 40,714	**Outcome Improvement Target 3** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 76.9% (or 3.9% improvement over baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $97,359
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $14,593	Year 3 Estimated Outcome Amount: $25,372	Year 4 Estimated Outcome Amount: $ 40,714	Year 5 Estimated Outcome Amount: $97,359
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 178,038			

Title of Outcome Measure (Improvement Target): IT-12.2 Cervical Cancer Screening (HEDIS 2012) (Non-Standalone Measure)

Unique RHP Outcome Identification Number: 121790303.3.7

Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description

IT-12.2: Cervical Cancer Screening (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.

As part of preventive care and screenings, cervical cancer screening is a standard practice that PCP/PCMHs provide for their patients. Education and regular exams can be the difference between early detection and death. By the end of the waiver, our goal is to have > 59.1% (or 6.8% improvement over baseline) of patients who are Baylor Clinic at Baylor Medical Center at Garland be screened for Cervical Cancer. This is a 6.8% improvement over baseline.
Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that 52.3% of patients at the Baylor Clinic at Baylor Medical Center at Garland have had a Cervical Cancer screening

Outcome Improvement Milestones

- DY3:
  - IT-12.2: Cervical Cancer Screening
    - Our goal is increase the % of patients that have received a Cervical Cancer screening to at least 54.7% (or 2.4% improvement over baseline)
- DY4:
  - IT-12.2: Cervical Cancer Screening
    - Our goal is increase the % of patients that have received a Cervical Cancer screening to at least 57.0% (or 5.3% improvement over baseline)

- DY5:
    - IT-12.2: Cervical Cancer Screening
        - Our goal is increase the % of patients that have received a Cervical Cancer screening to at least 59.1% (or 6.8% improvement over baseline)

In order to meet these improvements, primary care and specialists in the community will have to work together to meet these goals. We feel that OB/GYNs should handle more complex cases but also use this opportunity to help educate underserved women in Garland about the importance of screenings and prevention.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Metrics selected were based on historical data from similar programs with specialty care providers that showed material improvement in a 2-3 year time period

In Dallas County approximately the incidence rate of cervical cancer is 9.7 per 100,000.[426] According to the National Cancer Institute, African American women are more likely to be diagnosed with cervical cancer and Hispanic women have the highest cervical cancer incidence rate amongst all women.[427] In Garland, the African American population comprises 14.5% of the population, and Hispanics comprise 37.8%.[428] There is opportunity to increase the screenings in the minority population through engaging OB/GYNs to provide screenings and education for this population. Additionally, these specialists can provide the advanced screenings and education that would not be available in a PCP/PCMH setting.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.1.2- Improve Access to Specialty Care-Expand Specialty Care Services

[426] Healthy People North Texas: http://www.healthyntexas.org
[427] National Cancer Institute: http://www.cancer.gov
[428] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/4829000.html

121790303.3.7	*3.IT-12.2*	*Cervical Cancer Screening*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.1.2*- Improve Access to Specialty Care-Expand Specialty Care Services		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Garland had a screening rate of 52.3%* ***Target Population:*** *Underserved/uninsured women between the ages of 21-64 in Garland*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports/agreements with specialists Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 14,593	**Outcome Improvement Target 1** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 54.7% (or 2.4% improvement over baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 12,686	**Outcome Improvement Target 2** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 57.0% (or 5.3% improvement over baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 20,357	**Outcome Improvement Target 3** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 59.1% (or 6.8% improvement over baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 46,680
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 14,593	Year 3 Estimated Outcome Amount: $ 12,686	Year 4 Estimated Outcome Amount: $ 20,357	Year 5 Estimated Outcome Amount: $ 48,680
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 96,316			

Title of Outcome Measure (Improvement Target): IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-Standalone Measure)

Unique RHP Outcome Identification Number: 121790303.3.8

Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description

IT-12.3 Colorectal Cancer Screening (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.

By the end of the waiver, our goal is to have > 43.0% (or 9.5% improvement over baseline) of patients who are Baylor Clinic patients at Baylor Medical Center at Garland be screened for Colorectal Cancer. This is an improvement of 9.5% over baseline. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that only 33.5% of patients at Baylor Clinic at Baylor Medical Center at Garland have had a Colorectal Cancer Screening

Improvement Milestones

- DY3:
  - IT-12.3 Colorectal Cancer Screening
    - Our goal is increase the % of patients that have received a Colorectal Cancer screening to at least 36.8% (or 3.3% improvement over baseline)
- DY4:
  - IT-12.3 Colorectal Cancer Screening
    - Our goal is increase the % of patients that have received a Colorectal Cancer screening to at least 40.0% (or 6.5% improvement over baseline)
- DY5:

- IT-12.3 Colorectal Cancer Screening
  - Our goal is increase the % of patients that have received a Colorectal Cancer screening to at least 43.0% (or 9.5% improvement over baseline)

In order to meet these improvements, primary care and specialists in the community will have to work together to meet these goals. We feel that Gastroenterologists should handle more complex cases but also use this opportunity to help educate underserved adults about the importance of screenings and prevention. The Baylor Clinic is currently only at a 33% completion rate and will need the help of their specialist partners to meet these goals.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Metrics selected were based on historical data from similar programs with specialty care providers that showed material improvement in a 2-3 year time period

In Dallas County less than 60% of individuals 50 and over have had a sigmoidoscopy or colonoscopy examination. The colorectal cancer incidence rate is 43.3 cases per 100,000 people. 60% of deaths due to colorectal cancer can be avoided.[429] There is a definite need for these services in Dallas County and the Baylor Clinic plans to provide these screenings to a greater number of people. According to the Centers for Disease Control and Prevention, Hispanics and African Americans are less likely to get screened for colorectal cancer and it is often found in the latter stages of the disease as compared to their Caucasian counterparts.[430] In Garland, African Americans comprise 14.5% of the population and Hispanics, 37.8%.[431] There is an opportunity to increase the colorectal cancer screening rates by engaging specialists in the Dallas County area to provide these basic and advanced screenings along with education that is focused on this particular topic.

Outcome Measure Valuation:

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or

[429] Healthy People North Texas: http://www.healthyntexas.org
[430] Centers for Disease Control and Prevention: http://www.cdc.gov
[431] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/4829000.html

diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.1.2- Improve Access to Specialty Care-Expand Specialty Care Services

121790303.3.8	*3.IT-12.3*	*Colorectal Cancer Screening*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.1.2:* Improve Access to Specialty Care-Expand Specialty Care Services		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Garland had a screening rate of 33.5%* ***Target Population:*** *Underserved/uninsured adults between the ages of 50-75 in Dallas County (Garland).*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports/agreements with specialists Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 14,593	**Outcome Improvement Target 1** [IT-12.2]: Colorectal Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 36.8% (or 3.3% improvement over baseline) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 12,686	**Outcome Improvement Target 2** [IT-12.2]: Colorectal Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 40.0% (or 6.5% improvement over baseline) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 20,357	**Outcome Improvement Target 3** [IT-12.2]: Colorectal Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 43.0% (or 9.5% improvement over baseline) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 48,680
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 14,593	Year 3 Estimated Outcome Amount: $ 12,686	Year 4 Estimated Outcome Amount: $ 20,357	Year 5 Estimated Outcome Amount: $ 48,680
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 96,316			

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure)

Unique RHP Outcome Identification Number: 121790303.3.9

Performing Provider Name/TPI: Baylor Medical Center of Garland/121790303

Outcome Measure Description

IT-1.10 Diabetes care: *HbA1c poor control (>9.0%) (Standalone measure)*

- Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

By the end of the waiver, our goal is to have < 10.9% (or minimum reduction of 1.8% over baseline) of patients 18-75 years old with diabetes (type 1 or type 2) out of glycemic control (HbA1c >9.0%). This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program. The additional qualifiers for this metric are the following: 1) a patient has been engaged in chronic care management for at least 6 months, 2) Two HbA1c measures will be taken per patient and the most recent HbA1c score will be used for reporting.

One of the outcome measures we have chosen for our chronic care management program is HbA1c performance, as determined by a reduction in poor control, defined as the percent of the population with HbA1c > 9.0%. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

DY2:

P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-2: Establish Baseline Rate

We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that at least 12.7% of patients at the Baylor Clinic at Baylor Medical Center at Garland have an HbA1c > 9.0% Improvement Milestones

Outcome Improvement Targets for each year

DY3:

IT-1.10: Diabetes Care: HbA1c poor control (> 9.0%)
Our goal is to reduce the HbA1c > 9.0% rate to ≤ 12.1% (or 0.6% reduction over baseline)

DY4:

IT-1.10: Diabetes Care: HbA1c poor control (> 9.0%)
Our goal is to reduce the HbA1c > 9.0% rate to ≤ 11.5% (or 1.2% reduction over baseline)

DY5:

IT-1.10: Diabetes Care: HbA1c poor control (> 9.0%)
Our end goal is to have the HbA1c > 9.0% rate be ≤ 10.9% (or 1.8% reduction over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

In Dallas County, more than 11.4% of the population has a diagnosis of Diabetes.[432] Traditionally, the underserved population in Garland does not have access to the necessary medications and supplies to manage their diabetes thus many patients go undiagnosed or have poor glucose control. Lack of proper education coupled with a lack of primary care attention often leads to more severe complications and poor health outcomes for those with diabetes. This project would facilitate timely and appropriate care for those with diabetes and ensure that regular labs and point of care testing is completed to monitor results and make appropriate interventions.

Bodenheimer, et. al, found that patient self-management of chronic disease conditions, such as diabetes, that was co-located in a primary care setting led to significant improvement in HbA1c control in patients.[433] A recent of edition of Managed Care found that patients with an HbA1c > 9 had on average almost $5000 worth of hospitalization costs, while those with an HbA1c of < 7 had about $2700 in hospitalization costs[434]. Focusing efforts on improving glycemic control should result in reduced co-morbid conditions and improved complication rates for these patients. We expect that at least 5-7% of patients that are seen regularly in a Baylor Clinic will have improved HbA1c levels.

[432] RHP 9 Community Health Needs Assessment
[433] Bodenheimer, T., Lorig, K.., Holman, H., Grumbach, K. Patient Self-management of Chronic Disease in Primary Care *JAMA* (May 15, 2008).
[434] MenzinJ, Korn, J, Cohen, J, et.al Relationship between glycemic control and diabetes related hospital costs in patients with type 1 or type 1 diabetes mellitus. J Manag Care Pharm. 2010; 16(4):264-275.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.
weight to a hypertension or diabetes related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

Related Category 1 and/or 2 projects

121790303.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

121790303.3.9	*3.IT-1.10*	*Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure)*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2. An initial data analysis from our E.H.R shows that at least 12.7% of patients at the Baylor Clinic at Baylor Medical Center at Garland have an HbA1c > 9.0%* ***Target Population:*** *Uninsured/undeserved patients in Dallas County (Garland) with an HbA1c > 9.0%*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
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 reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 13,498 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 13,498	**Outcome Improvement Target 1** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure) Improvement Target: ≤12.1% (or 0.6% reduction over baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 24,341	**Outcome Improvement Target 2** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure) Improvement Target: ≤11.5% (or 1.2% reduction over baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment: $ 39,057	**Outcome Improvement Target 3** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure) Improvement Target: ≤10.9% (or 1.8% reduction over baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 93,392
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):$ 26,996	Year 3 Estimated Outcome Amount: $ 24,341	Year 4 Estimated Outcome Amount: $ 39,057	Year 5 Estimated Outcome Amount: $ 93,392
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 183,786			

Title of Outcome Measure (Improvement Target): IT-1.11 Diabetes Care: BP control (<140/80 mmHg) NQF 0061 (Standalone measure)

Unique RHP Outcome Identification Number: 121790303.3.10

Performing Provider Name/TPI: Baylor Medical Center of Garland/121790303

Outcome Measure Description

IT-1.11 Diabetes care: *BP control (<140/80mm Hg)- (Standalone measure)*

- Numerator: Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg.
- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

By the end of the waiver, our goal is to have > 54.9% (or 7.5% improvement over baseline) of patients 18-75 years old with diabetes (type 1 or type 2) under BP control (< 140/80 mmHg). This is a 7.5% improvement over baseline. This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program for at least 6 months. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish Baseline Rates
        - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that at least 47.4% of patients with diabetes at the Baylor Clinic at Baylor Medical Center at Garland have BP less than 130/80 mmHg. At Baylor Medical Center at Garland Medical Center, we have been historically defining uncontrolled BP > 130/80 mmHg, we will have to adjust our tracking for this project.

Outcome Improvement Targets for each year

DY3:

IT-1.11: Diabetes Care: BP control (<140/80 mmHg)

Our goal is increase the % of patients in good BP control (<140/80 mmHg) to 50.0% (or 2.6% improvement over baseline) of patients at the Baylor Clinic who have engaged in the chronic care management program

DY4:

IT-1.11: Diabetes Care: BP control (<140/80 mmHg)

Our goal is increase the % of patients in good BP control (<140/80 mmHg) to 52.5% (or 5.1% improvement over baseline) of patients at the Baylor Clinic who have engaged in the chronic care management program

DY5:

IT-1.11: Diabetes Care: BP control (<140/80 mmHg)

Our goal is increase the % of patients in good BP control (<140/80 mmHg) to 54.9% (or 7.5% improvement over baseline) of patients at the Baylor Clinic who have engaged in the chronic care management program

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

We will have to review our baseline numbers in DY2. Historically, in our E.H.R we have been tracking BP control as < 130/80 mmHg. In order to meet the requirements of this project, we will have to re-analyze the numbers and re-establish our new baseline.

As part of the standard of care for diabetes management, optimal blood pressure control is an included component of this protocol. At Baylor Health Care System, blood pressure control and management is a required part of the diabetes care bundle in order to avoid other co-morbid conditions such as heart disease and stroke. A 2010 study in the New England Journal of Medicine by Cushman, et. al showed that better and less severe health outcomes related to cardiovascular episodes and stroke were achieved with tight blood pressure control in diabetic patients[435]. Events that would be fatal with higher blood pressure became nonfatal under better blood pressure control in these studies completed. As part of an outpatient, clinic based protocol, blood pressure control can be achieved in patients who will come to the Baylor Clinic as part of the primary care expansion project.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome

[435] Cushman WC, Evans, GW, et. al Effects of intensive blood pressure control in type 2 diabetes mellitus. N Engl J Med. 2010. Apr 29; 362(17): 1575-85

,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

121790303.3.10	*3.IT-1.11*	*Diabetes Care: BP control (<140/80 mmHg)*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 and redefined as <140/80 mmHg. Currently, we have about 47.4% of our patients that have a BP < 130/80 mmHg at the Baylor Clinic at Baylor Medical Center at Garland.* ***Target Population:*** *Underserved/uninsured diabetic patients with BP >140/80 mmHg in Dallas County (Garland)*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 3,374 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 3,375	**Outcome Improvement Target 1** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Standalone measure) Improvement Target: > 50.0% (or 2.6% improvement over baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 24,338	**Outcome Improvement Target 2** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Standalone measure) Improvement Target: > 52.5% (or 5.1% improvement over baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 39,054	**Outcome Improvement Target 3** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Standalone measure) Improvement Target: > 54.9% (or 7.5% improvement over baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 93,392
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 6,749	Year 3 Estimated Outcome Amount: $ 24,338	Year 4 Estimated Outcome Amount: $ 39,054	Year 5 Estimated Outcome Amount: $ 93,392
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 163,533			

Title of Outcome Measure (Improvement Target): IT-1.13 Diabetes Care: Diabetes care: Foot exam- NQF 0056

Unique RHP Outcome Identification Number: 121790303.3.11

Performing Provider Name/TPI: Baylor Medical Center of Garland/121790303

Outcome Measure Description

IT-1.13 Diabetes care *Foot exam- (Non- standalone measure)*

- 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).

By the end of the waiver, our goal is to have > 96.8% (or a minimum of 1.2% improvement over baseline) of patients 18-75 years old with diabetes (type 1 or type 2) receive a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year(s). This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

DY2:

P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-2: Establish Baseline Rates

We will confirm and establish our baseline. A preliminary E.H.R data analysis shows 95.6% of diabetic patients that are seen by a diabetes educator at the Baylor Clinic at Baylor Medical Center at Garland receive a foot exam

Outcome Improvement Targets for each year

DY3:

IT-1.13: Diabetes Care: Foot exam

Our goal is to increase this rate to at least 96.0% (or a minimum of 0.4% improvement over baseline) of diabetic patients receiving a foot exam

DY4:

IT-1.13: Diabetes Care: Foot exam

Our goal is to increase this rate to at least 96.4% (or a minimum of 0.8% improvement over baseline) of diabetic patients receiving a foot exam

DY5:

IT-1.13: Diabetes Care: Foot exam

Our goal is to increase this rate to at least 96.8% (or a minimum of 1.2% improvement over baseline) of diabetic patients receiving a foot exam

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

An innovative part of this project is that the educators (CHWs and RN Care Managers) will be able to conduct diabetic foot exams as part of their education session with their patients. This will increase the rate of screening and allow these providers to identify issues such as ulcers and nerve issues earlier and more often. Foot exams are a low cost, highly effective way to avoid costly interventions such as wound care and management, amputations, neuropathy and other complex issues. This is better utilization and management of resources through early identification and prevention of serious diabetes foot related issues. It is recommended by the American Diabetes Association that diabetic patients receive yearly foot exams to determine if there are predisposing factors for ulceration and amputation.[436]

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

[436] American Diabetes Association: http://www.ada.org

121790303.3.11	*3.IT-1.13*	*Diabetes Care: Foot Exam*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2. An initial data analysis from our E.H.R shows that about 95.6% of diabetic patients seen by a diabetes educator at the Baylor Clinic at Baylor Medical Center at Garland receive a foot exam* ***Target Population:*** *Underserved/uninsured patients with diabetes in Dallas County (Garland)*		
Year 2 (10/1/2012 – 9/30/2013)	**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-3.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 6,749 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 6,749	**Outcome Improvement Target 1** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Standalone measure) Improvement Target: >96.0% (or 0.4% improvement over baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 6,084	**Outcome Improvement Target 2** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Standalone measure) Improvement Target: >96.4% (or 0.8% improvement over baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 9,763	**Outcome Improvement Target 3** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Standalone measure) Improvement Target: >96.8% (or 1.2% improvement over baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 23,349
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 13,498	Year 3 Estimated Outcome Amount: $ 6,084	Year 4 Estimated Outcome Amount: $ 9,763	Year 5 Estimated Outcome Amount: $ 23,349
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 52,694			

Title of Outcome Measure (Improvement Target): IT-11.1 Improvement in Clinical Indicator in Identified Disparity Group. Clinical indicator to be improved and disparity group to be determined by provider.

Unique RHP Outcome Identification Number: 121790303.3.12

Performing Provider Name/TPI: Baylor Medical Center of Garland/121790303

Outcome Measure Description

IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider *(Standalone measure)*

- Numerator: Number of patients with an improved Diabetes POA (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter
- Denominator: Total number of patients with a Behavioral Health intervention/
- encounter

One of the outcome measures we have chosen for our behavioral health program is to improve Baylor's standard diabetes Percent of Opportunities Achieved (POA) which consists of HbA1c, LDL, BP control for patients who have engaged in our behavioral health program. POA is similar in nature to an improvement bundle, but differs slightly in the way it is calculated. Here, we define the disparate population as the underserved individuals in Dallas County (Garland) that have both a diagnosis of diabetes and a behavioral health issue.

By the end of the waiver, our goal is to have > 15% of patients who have had a behavioral health intervention/encounter to have improvement in our Diabetes POA (HbA1c, LDL, BP, etc) that have uncontrolled values for these measures and have an identified behavioral health issue.

- HbA1c < 8%
- LDL < 100
- BP < 130/80 mmHg

Baylor's standard diabetes POA is measured by using percent of opportunities achieved (POA). We plan on measuring the improvement in Diabetes for Baylor Clinic patients that receive behavioral health treatment. The Diabetes POA which consists of: LDL, BP and HbA1c control is measured yearly for our diabetic patients. The POA is calculated by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population. POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in diabetes management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their diabetes patients than in the prior reporting period.

For an illustrative example: For Diabetes- there are 3 opportunities (i.e. metrics) per patient (1) A1c < 8, 2) LDL < 100, 3) BP < 130/80 mmHg). The denominator would be # of patients x 3. So, for example, if there are 10 patients x 3 opportunities each = 30 opportunities to be achieved. If, in the course of the year, only 20 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 20/30=67%. To achieve a 10% improvement in POA, we would have to have completed at least 23/30 opportunities to get at 77% achievement. We define this outcome in the following way:

Numerator: Number of patients with an improved Diabetes POA (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter

Denominator: Total number of patients with a Behavioral Health intervention/ encounter

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-3-2: Establish Baseline Rates
        - We will establish a baseline of current status of the Diabetes POA for patients that have a reported behavioral health issue
- DY3:
    - P-3-2: Establish Baseline Rates
        - We will compare the DY2 baseline rate to results in DY3 to measure change refine data collection processes if necessary

Outcome Improvement Targets for each year

- DY3:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Diabetes Percent of Opportunities Achieved in Behavioral Health patients)
        - We will improve the Diabetes POA for 5% of patients who have had at least one behavioral health intervention/encounter in one year
- DY4:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Diabetes Percent of Opportunities Achieved in Behavioral Health patients)
        - We will improve the Diabetes POA for 10% of patients who have had at least one behavioral health intervention/encounter in one year
- DY5:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Diabetes Percent of Opportunities Achieved in Behavioral Health patients
        - We will improve the Diabetes POA for 15% of patients who have had at least one behavioral health intervention/encounter in one year

Rationale

Category 3 metrics for this projects were identified using literature only. Baylor has had no previous experience with a behavioral health program of this nature. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting.

Our main goal by selecting this outcome was to recognize and increase awareness of patients who have co-occurring behavioral health and diabetes health issues. By recognizing this, we believe we can positively impact diabetes outcomes by addressing underlying behavioral health issues that patients may have.

In DY2, we will collect our baseline information about the status of the Diabetes Metrics (HbA1c, LDL, BP) for patients who have a documented behavioral health issue. The problem with this collection is that because this program is new, both patients and clinicians are not actively looking for and documenting behavioral health problems that patients have. As part of our project, we plan to increase screenings using PHQ2/9, GAD-7 and substance abuse tools but until that is implemented, the numbers we will be reporting for baseline will be underreported. Once there is more awareness about the screenings and program, we anticipate that more patients will disclose their behavioral health issue and their providers will also be more aware of these conditions.

We believe if we increase the treatment rates of behavioral health issues, that we will also see an increase in patient compliance rates with other preventive screening/testing and clinical recommendations made by their providers.
In Region 9, there is a 36% increase in average charges per encounter for those individuals with a co-occurring behavioral health issue and chronic disease. 100% of the frequent flyers had a co-occurring mental illness and cost the Region over $26 million dollars.[437]

A recent study conducted in early 2012, by Jeffery Johnson, et. al showed a direct correlation between diabetes and depression. They cited that depression is the most common co-morbid condition present in 15-30% of patients with Type 2 diabetes and less than 50% are recognized as having depression. Depression is associated with poorer self care behaviors, decreased quality of life and substantially higher health care costs. Both diabetes and behavioral health issues are prevalent across the region, warranting measurement of the efficacy of a behavioral health program on chronic diseases[438].

[437] RHP 9 Community Health Needs Assessment

[438] Johnson, JA, Sayah, FA, et.al. Controlled trial of a collaborative primary care team model for patients with diabetes and depression: rationale and design for a comprehensive evaluation. BMC Health Services Research. 2012, 12:358

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.2.2: Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment

121790303.3.12	*IT-11.1*	*Improvement in clinical indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider- Diabetes POA improvement*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.2.2- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:	***Definition of Metric**:* *Numerator: Number of patients with an improved Diabetes Percent of Opportunities Achieved (POA) improvement (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter* *Denominator: Total number of patients with a Behavioral Health intervention/encounter* ***Baseline:** The baseline for Baylor Medical Center at Garland will be established in DY2.* ***Target Population:** On average, 15-30% of patients with Diabetes have a co-morbid behavioral health diagnosis (usually Depression), which would mean approximately 35,000-65,000 people in the Garland area*		
Year 2 (10/1/2012 – 9/30/2013)	**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 Goal: Complete planning processes for behavioral health program Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 10,772 **Process Milestone 2** [P-2]: Establish baseline rates Metric: Determine current status of patients with co-occurring illnesses Goal: Determine number of	**Process Milestone 3** [P-2]: Establish baseline rates Metric: Compare DY2 baseline assessment of patients with uncontrolled Diabetes POA and documented behavioral health issues to DY3 data period Goal: Determine if more self or clinician reported data around identification of behavioral health issues has an impact on DY2 baseline reporting Data Source: E.H.R Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 12,485 **Outcome Improvement Target 1** [IT-11.1]: Improve Clinical Indicator in identified disparity group. Improvement Target:	**Outcome Improvement Target 2** [IT-11.1]: Improve Clinical Indicator in identified disparity group. Improvement Target: Improve Diabetes POA (HbA1c, LDL, BP) for at least 10% of patients who have had at least 1 behavioral health encounter/intervention Numerator: # of patients with improved Diabetes POA Denominator: # of patients with at least 1 behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 53,426	**Outcome Improvement Target 3** [IT-11.1]: Improve Clinical Indicator in identified disparity group. Improvement Target: Improve Diabetes POA (HbA1c, LDL, BP) for at least 15% of patients who have had at least 1 behavioral health encounter/intervention Numerator: # of patients with improved Diabetes POA Denominator: # of patients with at least 1 behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 127,757

121790303.3.12	*IT-11.1*	*Improvement in clinical indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider- Diabetes POA improvement*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.2.2- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:	***Definition of Metric**:* *Numerator: Number of patients with an improved Diabetes Percent of Opportunities Achieved (POA) improvement (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter* *Denominator: Total number of patients with a Behavioral Health intervention/encounter* ***Baseline:** The baseline for Baylor Medical Center at Garland will be established in DY2.* ***Target Population:** On average, 15-30% of patients with Diabetes have a co-morbid behavioral health diagnosis (usually Depression), which would mean approximately 35,000-65,000 people in the Garland area*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
patients with out of range Diabetes POA (HbA1c, LDL, BP) that have a documented behavioral health issue Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 10,771	Improve Diabetes POA (HbA1c, LDL, BP) for at least 5% of patients who have had at least 1 behavioral health encounter/intervention Numerator: # of patients with improved Diabetes POA Denominator: # of patients with at least 1 behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 12,486		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 21,543	Year 3 Estimated Outcome Amount: $ 24,971	Year 4 Estimated Outcome Amount: $ 53,426	Year 5 Estimated Outcome Amount: $ 127,757
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 227,697			

Title of Outcome Measure (Improvement Target): IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services and treatment) in target population with identified disparity. (**Non-standalone measure**)

Unique RHP Outcome Identification Number: 121790303.3.13

Performing Provider Name/TPI: Baylor Medical Center of Garland/121790303

Outcome Measure Description

IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services and treatment) in target population with identified disparity. *(Non-standalone measure)*

- Numerator: patients who are Baylor clinic patient who engage in a behavioral health treatment/intervention
- Denominator: patients who are Baylor clinic patients who are eligible for behavioral health services

One of the outcome measures we have chosen for our behavioral health program is to increase the number of patients in the underserved population who have improved utilization rates for receiving behavioral health treatments/interventions. The subset of the target population that suffers from mental health issues is prevalent in the region. Only 19.8% of underserved patients receive behavioral treatment in the same setting as their primary care[439]. The disparate population that we will be focusing on is the underserved/uninsured patients in Dallas County (Garland) with behavioral health needs.

By the end of the waiver, our goal is to have > 20% of patients who are eligible to participate in the behavioral health program, engage in the program.

We define this outcome in the following way:

Numerator: patients who are Baylor clinic patient who engage in a behavioral health treatment/intervention
Denominator: patients who are Baylor clinic patients who are eligible for behavioral health services

The idea of this metric is that by engaging patients in behavioral health treatment/interventions that their subsequent medical care will also improve. Patients who engage are those who have had at least two behavioral health interventions/encounters in the past 12 months. Patients eligible for behavioral health entail those that have 1) been identified through the PHQ2/9, GAD-7 and Substance Abuse screening tools that are in need of intervention, 2) self- identified need or 3) provider/clinician identification of patient need for behavioral health counseling. This Outcome Measure is different than the Improvement Milestone we proposed in our

[439] RHP 9 Community Health Needs Assessment

Category 2 Project Table because Outcome Measure 11.3 focuses on utilization of the behavioral health service, entailing that an "engaged" patient is one that has had at least two behavioral health encounters/interventions in the past 12 months. The Improvement Milestone in the project table is a volume metric focused on enrolling the patient in a Behavioral Health program. This Outcome Measure takes this one step further by requiring at least two visits in the past 12 months.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish Baseline Rates
    - We will establish a baseline of how many patients have a behavioral health issue (substance abuse, anxiety, depression, other) based on our E.H.R, self-reported or clinician reported status.
- DY3:
  - P-2: Establish Baseline Rates
    - We will compare our DY2 baseline analysis to DY3 to determine if any improvements need to be made to the data collection process and to capture any variances between the two data sets

Outcome Improvement Targets for each year

- DY3:
  - IT-11.3: Improve utilization rates of clinical preventive services
    - We will improve behavioral health treatment rates by 10%
- DY4:
  - IT-11.3: Improve utilization rates of clinical preventive services
    - We will improve behavioral health treatment rates by 15%
- DY5:
  - IT-11.3: Improve utilization rates of clinical preventive services
    - We will improve behavioral health treatment rates by 20%

Rationale

Category 3 metrics for this projects were identified using literature only. Baylor has had no previous experience with a behavioral health program of this nature. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting.

Our main goal by selecting this outcome was to demonstrate increased access and utilization of the behavioral health program we are proposing.

In DY2, we will collect our baseline information about the number of patients who have a behavioral health issue. The problem with this collection is that because this program is new, both patients and clinicians are not actively looking for and documenting behavioral health problems that patients have. As part of our project, we plan to increase screenings using PHQ2/9, GAD-7 and substance abuse tools but until that is implemented, the numbers we will be reporting for baseline will be underreported. Once there is more awareness about the screenings and program, we anticipate that more patients will disclose their behavioral health issue and their providers will also be more aware of these conditions.

We believe if we increase the treatment rates of behavioral health issues, that we will also see an increase in patient compliance rates with other preventive screening/testing and clinical recommendations made by their providers.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.2.2: Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment

121790303.3.13	*3.IT-11.3*	*Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. The disparate population is the underserved/uninsured patients with behavioral health issues.*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.2.2: Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals-Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor Medical Center at Garland will be established in DY2.* ***Target Population:*** *The target population in the Dallas county area is over 53,000 underserved individuals in Garland who suffer from a mental illness*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 10,771 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 10,772	**Process Milestone 3** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 3 Estimated Incentive Payment: $ 12,485 **Outcome Improvement Target 1** [IT-11.3]: Improve utilization rates of clinical preventive services Improvement Target: Increase rate of patient engagement by 10% Numerator: # of patients engaged in behavioral health treatment/intervention Denominator: # of patients eligible for behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $12,486	**Outcome Improvement Target 2** [IT-11.3]: Improve utilization rates of clinical preventive services Improvement Target: Increase rate of patient engagement by 15% Numerator: # of patients engaged in behavioral health treatment/intervention Denominator: # of patients eligible for behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 26,713	**Outcome Improvement Target 3** [IT-11.3]: Improve utilization rates of clinical preventive services Improvement Target: Increase rate of patient engagement by 20% Numerator: # of patients engaged in behavioral health treatment/intervention Denominator: # of patients eligible for behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 63,878
Year 2 Estimated Outcome Amount: $ 21,543	Year 3 Estimated Outcome Amount: $ 24,971	Year 4 Estimated Outcome Amount: $ 26,713	Year 5 Estimated Outcome Amount: $ 63,878
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 137,105			

Title of Outcome Measure (Improvement Target): IT-5.1 Improved Cost Savings: Demonstrate cost savings in care delivery (Non-**Standalone measure**)

Unique RHP Outcome Identification Number: 121790303.3.14

Performing Provider Name/TPI: Baylor Medical Center of Garland/121790303

Outcome Measure Description

IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (*Standalone measure for Project 2.5 only. For all other projects –Non- standalone measure)*

- Type of analysis to be determine by provider from the following list: Cost of Illness Analysis, Cost Minimization Analysis, Cost Effectiveness Analysis (CEA), Cost Consequence Analysis, Cost Utility Analysis, Cost Benefit Analysis

By the end of the waiver, our goal is to have > 30% cost savings in health care services utilization (through fewer ED visits and less overall utilization) for patients who have engaged in our care navigation program and have a confirmed appointment with a PCP/PCMH.

One of the outcome measures we have chosen for our care navigation program is to improve cost savings in the healthcare delivery system for those patients that have been served by the care navigation program.

Process Milestones

DY2:

P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-2: Establish Baseline Rates

In DY2 we will establish a baseline of average cost savings incurred by patients who have been seen by the care navigation program while in the ED and have a confirmed appointment with a PCP/PCMH. We will compare pre and post utilization patterns of enrolled patients to determine the total cost savings incurred (inpatient and outpatient) per patient. For example, if prior to being seen by our care navigation program, a patient's total cost utilization was $10,000 we anticipate that after being connected to the appropriate resource and being seen for an appointment that over the course of 1 year, total costs would decrease by 20% (DY4) to $8,000.

Outcome Improvement Targets for each year

DY3:

IT-5.2: Improved Cost Savings

We aim to improve cost savings for those patients that have been 1) seen by our care navigation and program and 2) have a confirmed appointment by 15% using a pre/post analysis of utilization patterns for total cost of care over the course of 1 year

DY4:

IT-5.2: Improved Cost Savings

We aim to improve cost savings for those patients that have been 1) seen by our care navigation and program and 2) have a confirmed appointment by 20% using a pre/post analysis of utilization patterns for total cost of care over the course of 1 year

DY5:

IT-5.2: Improved Cost Savings

We aim to improve cost savings for those patients that have been 1) seen by our care navigation and program and 2) have a confirmed appointment by 25% using a pre/post analysis of utilization patterns for total cost of care over the course of 1 year

Rationale

In DY2, we plan to do some in depth utilization analysis to determine a baseline of what the cost utilization patterns are for patients seen at Baylor Medical Center at Garland. This, based on our historical experience with similar programs on other campuses, we anticipate a 15%, 20% and 25% cost savings over the subsequent years in total cost of care savings.

The reason we chose this metric is because financial constraints are a main concern for the Region in being able to provide high quality care to the underserved population. Cost savings and effectiveness are a key part of the overall Waiver and require providers to be good stewards of their resources. This metric is appropriate because it emphasizes appropriate utilization of resources and reinforces the concept of cost effectiveness. We plan to measure the cost effectiveness and cost utilization of this project. According to the Texas Medical Association, the cost of treating a condition that could be treated in the doctor's office for $56.21 (including lab and x-ray) costs $193.92 in the Emergency room[440]. This cost differential multiplied by the 443,000 uninsured in Dallas County creates a significant cost to the county and Region.

[440] Texas Medical Association: http://www.texmed.org

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect

121790303.3.14	*3.IT-5.1*	*Improved cost savings: demonstrate cost savings in care delivery*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor Medical Center at Garland will be established in DY2. Typical costs for an inpatient stay for an uninsured patient is $19,400* ***Target Population:*** *Underserved/uninsured patients without a PCP/PCMH in Dallas County (Garland).*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 10,684 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 10,685	**Outcome Improvement Target 1** [IT-5.1]: Improved Cost Savings Improvement Target: For patients that have been seen by the care navigation program, have a confirmed PCP/PCMH appointment, cost savings should be 15% in a pre-post utilization analysis Data Source: E.H.R/Care Navigation database Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 16,513	**Outcome Improvement Target 2** [IT-5.1]: Improved Cost Savings Improvement Target: For patients that have been seen by the care navigation program, have a confirmed PCP/PCMH appointment, cost savings should be 20% in a pre-post utilization analysis Data Source: E.H.R/Care Navigation database Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 26,498	**Outcome Improvement Target 3** [IT-5.1]: Improved Cost Savings Improvement Target: For patients that have been seen by the care navigation program, have a confirmed PCP/PCMH appointment, cost savings should be 25% in a pre-post utilization analysis Data Source: E.H.R/Care Navigation database Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 63,365
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 21,369	Year 3 Estimated Outcome Amount: $ 16,513	Year 4 Estimated Outcome Amount: $ 26,498	Year 5 Estimated Outcome Amount: $ 63,365
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 127,745			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization (**Standalone measure**)

Unique RHP Outcome Identification Number: 121790303.3.15

Performing Provider Name/TPI: Baylor Medical Center of Garland/121790303

Outcome Description

IT-9.2 ED appropriate utilization *(Standalone measure)*

- Reduce all ED visits (including ACSC)
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)-N/A
- Reduce Emergency Department visits for target conditions
    - Congestive Heart Failure
    - Diabetes
    - End Stage Renal Disease
    - Cardiovascular Disease/Hypertension
    - Behavioral Health/Substance Abuse
    - Chronic Obstructive Pulmonary Disease
    - Asthma

By the end of the waiver, our goal is to have > 35% reduction in inappropriate ED utilization for all causes and > 20% reduction in inappropriate ED utilization for targeted conditions: CHF, Diabetes, ESRD, CVD/Hypertension, Behavioral Health/Substance Abuse, COPD and Asthma

One of the outcome measures we have chosen for our care navigation program is to reduce ED utilization. The protocol mentions three parts to this metric:

1) Reduce all ED visits (including ACSC)
2) Reduce pediatric Emergency Department visits (CHIPRA Core Measure)-*we will not be measuring this outcome as we do not see pediatric patients at Baylor University Medical Center*
3) Reduce ED visits for target conditions
    a. CHF
    b. Diabetes
    c. ESRD
    d. CVD/Hypertension
    e. Behavioral Health/Substance Abuse
    f. COPD
    g. Asthma

Process Milestones

DY2:

P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-3: Establish Baseline Rates

We will establish a baseline for the aforementioned components of the improvement metric (less #2- pediatric ED visits) and determine the full opportunity for improvement

DY3:

P-3 Establish Baseline Rates

We will conduct a comparison between DY2 and DY3 to determine the change in rates for ED utilization and utilization of targeted conditions and determine any seasonality or variations in data collection/trends

Improvement Milestones

DY3:

IT-9.2: ED Appropriate Utilization

We aim to reduce all ED visits by 25% and ED visits for targeted conditions by 10%

DY4:

IT-9.2: ED Appropriate Utilization

We aim to reduce all ED visits by 30% and ED visits for targeted conditions by 15%

DY5:

IT-9.2: ED Appropriate Utilization

We aim to reduce all ED visits by 35% and ED visits for targeted conditions by 20%

Rationale

Baylor Medical Center at Garland sees very few children, thus metric 2 is not applicable to this project. We do not see enough pediatric patients to make a material impact on the ED utilization rate for this population. Historically, we have not tracked the ED utilization for targeted conditions (i.e. CHF, Diabetes, etc), for this type of project thus we do not have a baseline measurement for these specific diseases. We plan to measure these in DY2 and DY3 and target a modest improvement of ED utilization in the subsequent years.

According to the Community Health Needs Assessment of Region 9, 68% of ED visits were preventable/treatable in an outpatient setting[441]. The stakeholder survey conducted amongst

[441] RHP 9 Community Health Needs Assessment

performing providers also indicated that there is a significant overuse of emergency department services due to patients' inability to access primary care. This metric is at the heart of the care navigation project we are proposing and will have a direct impact on patients in Dallas County utilizing the ED at a decreased rate. This project uses the popular concept created by Dr. Atul Gawande, referred to as "hot spotting" indicating a focus on finding the high risk/high utilization rates of the ED and determining the root cause for these visits, and then working to remedy those issues[442]. Issues such as transportation, navigation of community and appropriate resources are just two examples that can lead to more effective use of the ED.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect

[442] Gawande, A. The hot spotters: can we lower medical costs by giving the neediest patients better care? The New Yorker. (2011).

121790303.3.15	*3.IT-9.2*	*ED Appropriate Utilization*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.2.3- Establish/Expand a Patient Care Navigation Program-Care Connect*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor Medical Center at Garland will be established in DY2. Based on historical performance of similar programs, ED utilization typically decreased by 30% in the first year.* ***Target Population:*** *Underserved/uninsured patients without a PCP/PCMH that are frequent users of the ED*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 10,684 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 10,685	**Process Milestone 3** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 16,513 **Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED Utilization for All ED Visits by 25% for those patients who have been served by the care navigation program and have a confirmed appointment with the PCP/PCMH Improvement Target: Reduce ED utilization for patients with targeted conditions (CHF, Diabetes, etc) that have been served by the care navigation program and have a confirmed appointment with a PCP/PCMH by 10% Data Source: E.H.R/Care Navigation database Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 16,513	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED Utilization for All ED Visits by 30% for those patients who have been served by the care navigation program and have a confirmed appointment with the PCP/PCMH Improvement Target: Reduce ED utilization for patients with targeted conditions (CHF, Diabetes, etc) that have been served by the care navigation program and have a confirmed appointment with a PCP/PCMH by 15% Data Source: E.H.R/Care Navigation database Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 52,996	**Outcome Improvement Target 3** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED Utilization for All ED Visits by 35% for those patients who have been served by the care navigation program and have a confirmed appointment with the PCP/PCMH Improvement Target: Reduce ED utilization for patients with targeted conditions (CHF, Diabetes, etc) that have been served by the care navigation program and have a confirmed appointment with a PCP/PCMH by 20% Data Source: E.H.R/Care Navigation database Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 126,727

121790303.3.15	*3.IT-9.2*	*ED Appropriate Utilization*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.2.3- Establish/Expand a Patient Care Navigation Program-Care Connect*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor Medical Center at Garland will be established in DY2. Based on historical performance of similar programs, ED utilization typically decreased by 30% in the first year.* ***Target Population:*** *Underserved/uninsured patients without a PCP/PCMH that are frequent users of the ED*		
Year 2 (10/1/2012 – 9/30/2013)	**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): $ 21,369	Year 3 Estimated Outcome Amount: $ 33,026	Year 4 Estimated Outcome Amount: $ 52,996	Year 5 Estimated Outcome Amount: $ 126,727
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 234,118			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life
Unique RHP Outcome Identification Number: 121790303.3.16
Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description:
IT-10.1: Quality of Life *(Standalone measure)*

Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.

By the end of the waiver, our goal is to improve the mean score (average change from patient enrollment to most recent survey) on Quality of Life assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 7% over DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will determine the Quality of Life tool that will be used for this outcome
    - P-2: Establish baseline rates
        - We will confirm and establish our baseline. We do not currently utilize Quality of Life surveys. In a transitional care program for the elderly currently in existence at Baylor Health Care System, clinicians site that that Quality of Life indicators such as depression and cognition exams improve over time with home visits.

Outcome Improvement Targets for each year

- DY3:
    - IT-1.10: Quality of Life (Standalone)
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Quality of Life assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 3% over DY2.
- DY4:
    - IT-1.10: Quality of Life (Standalone)
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Quality of Life assessments for

patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 5% over DY2.

- DY5:
  - IT-1.10: Quality of Life (Standalone)
    - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Quality of Life assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 7% over DY2.

Rationale

Quality of Life assessments such as the SF-36 or AQoL measure components such as: illness, independent living, social relationships, physical senses and psychological wellbeing and will be important to measure in the high risk and vulnerable patients we intend to serve.[443] Understanding social and physical attributes of the patient will be essential in determining their feasibility of following protocols and regimens that will optimize their healthcare. We plan on conducting a QOL assessment every 6 months on patients who have been in the program for at least 6 months. Improvement will be measured from the time the patient is enrolled to time of survey administration.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.2.4-Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)

[443] Hawthorne, G. The assessment of quality of life instrument: a psychometric measure of health related quality of life. *Qual Life Res.*8(3):209-24 (1999)

121790303.3.16	*3.IT-10.1*	*Quality of Life*	
Baylor Medical Center at Garland			*121790303*
Related Category 1 or 2 Projects:	*121790303.2.4– Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)*		
Starting Point/Baseline:	***Baseline:*** *Baseline will be established in DY2. We do not currently track ADL assessments and improvements.* ***Target Population:*** *High risk, vulnerable patients who are unable to access care in an ambulatory care setting. The top 5% of high risk uninsured and Medicaid patients from the 872,000 uninsured in Dallas County.*		
Year 2 (10/1/2012 – 9/30/2013)	**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-1.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports and Quality of Life assessment tool Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $7,402 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $7,402	**Outcome Improvement Target 1** [IT-10.1]: Quality of Life (Standalone) Improvement Target: > 3% improvement in mean Quality of Life scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $17,159	**Outcome Improvement Target** IT-10.1]: Quality of Life (Standalone) Improvement Target: > 5% improvement in mean Quality of Life scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $27,535	**Outcome Improvement Target 3** IT-10.1]: Quality of Life (Standalone) Improvement Target: > 7% improvement in mean Quality of Life scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 65,844
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 14,804	Year 3 Estimated Outcome Amount: $17,159	Year 4 Estimated Outcome Amount: $27,535	Year 5 Estimated Outcome Amount: $65,844
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 125,342			

Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living
Unique RHP Outcome Identification Number: 121790303.3.17
Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description:
IT-10.2: Activities of Daily Living *(Standalone measure)*

Demonstrate improvement in ADL scores, as measured by evidence based and validated assessment tool, for the target population.

By the end of the waiver, our goal is to improve the mean score (average change from patient enrollment to most recent survey) on Activities of Daily Living assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 7% over DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will determine the Activities of Daily Living tool that will be used for this outcome
    - P-2: Establish baseline rates
        - We will confirm and establish our baseline. In a transitional care program for the elderly currently in existence at Baylor Health Care System, clinicians site that ADL improvement in the elderly population improves where patients go from partial dependence to independence.

Outcome Improvement Targets for each year

- DY3:
    - IT-10.2: Activities of Daily Living *(Standalone measure)*
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Activities of Daily Living assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 3% over DY2.
- DY4:
    - IT-10.2: Activities of Daily Living *(Standalone measure)*
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Activities of Daily Living

assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 5% over DY2.

- DY5:
  - IT-10.2: Activities of Daily Living *(Standalone measure)*
    - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Activities of Daily Living assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 7% over DY2.

Rationale

Measurement of the activities of daily living is critical because they have been found to be significant predictors of paid home care , use of hospital services, living arrangements, use of physician, insurance coverage and mortality.[444] While ADLs are typically used with the elderly population, the complexity and nature of the high risk uninsured/Medicaid patients warrants this assessment as well. Monitoring the progress or decline of factors such as bathing, feeding, continence, transferring, toileting and dressing are immediate predictors of any issues or barriers that patients may be experiencing.[445] We may need to consider using the Lawton IADL scale for this population as it involves more complex activities such as: shopping, laundry, responsibility for own medications, etc.[446] We plan on conducting the ADL assessment every 6 months and patients that have been in the program for 6 months. The improvement will be measured from the time that patients enroll in the program to survey conduction.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

[444] Measuring ADLs Across National Surveys: http://aspe.hhs.gov/daltcp/reports/meacmpes.htm

[445] Katz, Sidney. 1983. "Assessing Self-Maintenance: Activities of Daily Living, Mobility, and Instrumental Activities of Daily Living." *Journal of the American Geriatrics Association* 31:721-727.

[446] Lawton, M. Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living. *The Gerontologist* 9:179-186.

121790303.2.4-Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)

121790303.3.17	*3.IT-10.2*	*Activities of Daily Living*

Baylor Medical Center at Garland	*121790303*
Related Category 1 or 2 Projects:	*121790303.2.4– Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)*
Starting Point/Baseline:	***Baseline:*** *Baseline will be established in DY2. We do not currently track ADL assessments and improvements.* ***Target Population:*** *High risk, vulnerable patients who are unable to access care in an ambulatory care setting. The top 5% of high risk uninsured and Medicaid patients from the 872,000 uninsured in Dallas County.*

Year 2 (10/1/2012 – 9/30/2013)	**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-1.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports. Documentation of ADL assessment tool chosen Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $7,402 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $7,402	**Outcome Improvement Target 1** [IT-10.2]: Quality of Life (Standalone) Improvement Target: > 3% improvement in mean ADL scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment: $17,159	**Outcome Improvement Target** [IT-10.2]: Quality of Life (Standalone) Improvement Target: > 5% improvement in mean ADL scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $27,535	**Outcome Improvement Target 3** [IT-10.2]: Quality of Life (Standalone) Improvement Target: > 7% improvement in mean ADL scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 65,844
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 14,804	Year 3 Estimated Outcome Amount: $ $17,159	Year 4 Estimated Outcome Amount: $27,535	Year 5 Estimated Outcome Amount: $ 65,844
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 125,342			

Title of Outcome Measure (Improvement Target): IT-1.2 Annual monitoring for patients on persistent medication– angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (*Non- standalone measure*)
Unique RHP Outcome Identification Number: 121790303.3.18

Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description:
IT-1.2: Annual monitoring for patients on persistent medications angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (*Non- standalone measure*)
Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
Percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Since we do not have a baseline for patients receiving a serum potassium, serum creatinine or blood urea nitrogen test during the measurement year, we are proposing the following tiers of improvement:

- If 25-50% of patients on an ACE/ARB inhibitor are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 5% in DY3, 10% in DY4 and 15% in DY5 (all over DY2 baseline)
- If 50-75% of patients on an ACE/ARB inhibitor are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 5% in DY3, 7% in DY4 and 9% in DY5 (all over DY2 baseline)
- If 75-90% patients on an ACE/ARB inhibitor are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 2% in DY3, 4% in DY4 and 6% in DY5 (all over DY2 baseline)
- If 90% or more patients on an ACE/ARB inhibitor are receiving a serum potassium/creatinine or BUN test within one year then we will not pursue this outcome improvement and will defer to using only IT-1.19 Antidepressant Medication Management (Standalone)

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
        - We will establish our baseline rate. Based on clinician input, we believe about 33% of patients in Baylor Clinics are on an ACE/ARB

inhibitor. We do not have any data on how many of those patients received a serum potassium/creatinine or BUN test in the past year.

Outcome Improvement Targets for each year

- DY3:
  - IT-1.2: Annual monitoring for patients on ACE or ARBs (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 2% or 5% depending on baseline established in DY2
- DY4:
  - IT-1.2: Annual monitoring for patients on ACE or ARBs (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 4%, 5% or 10% depending on baseline in DY2
- DY5:
  - IT-1.2: Annual monitoring for patients on ACE or ARBs (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 6%, 9% or 15% depending on the baseline in DY2

Rationale

Approximately 33% of Baylor Clinic patients are on an ACE/ARB medication regimen. Enforcing annual monitoring will improve quality and reconcile the patient's medication to ensure it is still appropriate. In a recent study in the New England Journal of Medicine, compliance to anti-hypertensives was 41%, beta blockers was 49% and statins were 55% after a patient suffered from an AMI.[447] We believe through consistent, proactive management and encouraging patient accountability for taking medications, these rates should increase.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or

[447] Choudhry, NK, Avorn, J, et. al. Full coverage for preventive medications after myocardial infarction. N Engl J Med 2011; 365:2088-2097

diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.2.5- Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

121790303.3.18	*3.IT-1.2*	*Annual monitoring for patients on persistent medication– angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)*

Baylor Medical Center at Garland	*121790303*
Related Category 1 or 2 Projects:	*121790303.2.5– Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 33% of Baylor Clinic patients take an ACE or ARB inhibitor. We do not know the rate of monitoring for serum potassium/creatinine or BUN.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on an ACE/ARB inhibitor*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $3282 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $3282	**Outcome Improvement Target 1** [IT-1.2]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) ACE inhibitors or ARBs (*Non- standalone measure*) Improvement Target: > 2% of patient 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $7608	**Outcome Improvement Target 2** [IT-1.2]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) ACE inhibitors or ARBs (*Non- standalone measure*) Improvement Target: > 4% of patient 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $12,209	**Outcome Improvement Target 3** [IT-1.2]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) ACE inhibitors or ARBs (*Non- standalone measure*) Improvement Target: > 6% of patient 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $29,195
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $6,564	Year 3 Estimated Outcome Amount: $7,608	Year 4 Estimated Outcome Amount: $12,209	Year 5 Estimated Outcome Amount: $29,195
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $55,576			

Title of Outcome Measure (Improvement Target): IT-1.4 Annual monitoring for patients on persistent medications diuretic *(Non- standalone measure)*

Unique RHP Outcome Identification Number: 121790303.3.19

Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description:
IT-1.4: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non- standalone measure)*
Percentage of members 18 years of age and older who received at least 180 treatment days of a diuretic during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Since we do not have a baseline for patients receiving a serum potassium, serum creatinine or blood urea nitrogen test during the measurement year, we are proposing the following tiers of improvement:

- If 25-50% of patients on a diuretic are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 5% in DY3, 10% in DY4 and 15% in DY5 (all over DY2 baseline)
- If 50-75% of patients on a diuretic are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 5% in DY3, 7% in DY4 and 9% in DY5 (all over DY2 baseline)
- If 75-90% patients on a diuretic are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 2% in DY3, 4% in DY4 and 6% in DY5 (all over DY2 baseline)
- If 90% or more patients on a diuretic are receiving a serum potassium/creatinine or BUN test within one year then we will not pursue this outcome improvement and will defer to using only IT-1.19 Antidepressant Medication Management (Standalone)

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
        - We will establish our baseline rate. Based on clinician input, we believe about 33% of patients in Baylor Clinics are on a diuretic. We do not have any data on how many of those patients received a serum potassium/creatinine or BUN test in the past year.

Outcome Improvement Targets for each year

- DY3:
  - IT-1.4: Annual monitoring for patients a diuretic (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 2% or 5% depending on baseline established in DY2
- DY4:
  - IT-1.4: Annual monitoring for patients a diuretic (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 4%, 5% or 10% depending on baseline in DY2
- DY5:
  - IT-1.4: Annual monitoring for patients a diuretic (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 6%, 9% or 15% depending on the baseline in DY2

Rationale

Approximately 33% of Baylor Clinic patients on a diuretic medication regimen. Enforcing annual monitoring will improve quality and reconcile the patient's medication to ensure it is still appropriate. A study that observed the correlation between a diuretic regimen and cardiovascular related hospitalizations found that patients who take the appropriate dose of diuretics at the appropriate time had a decrease risk of cardiovascular and heart failure related hospitalizations. A large component of the successful adherence was attributed to patient education and engagement in the medication regimen.[448]

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or

[448] Chui, M. A., Deer, M., Bennett, S. J., Tu, W., Oury, S., Brater, D. C. and Murray, M. D. (2003), Association Between Adherence to Diuretic Therapy and Health Care Utilization in Patients with Heart Failure. Pharmacotherapy, 23: 326–332. doi: 10.1592/phco.23.3.326.32112

diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.2.5- Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

121790303.3.19	*3.IT-1.4*	*Annual monitoring for patients on persistent medications diuretic (Non- standalone measure)*

Baylor Medical Center at Garland	*121790303*

Related Category 1 or 2 Projects:	*121790303.2.5***–** *Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 33% of Baylor Clinic patients take a diuretic. We do not know the rate of monitoring for serum potassium/creatinine or BUN.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on a diuretic*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $3282 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $3282	**Outcome Improvement Target 1** [IT-1.4]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non- standalone measure)* Improvement Target: > 2% of patient 18 years of age and older who received at least 180 treatment days of diuretics during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $7608	**Outcome Improvement Target 2** [IT-1.4]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non-standalone measure)* Improvement Target: > 4% of patient 18 years of age and older who received at least 180 treatment days of diuretics during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $12,209	**Outcome Improvement Target 3** [IT-1.4]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non-standalone measure)* Improvement Target: > 6% of patient 18 years of age and older who received at least 180 treatment days of diuretics during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $29,195
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $6,564	Year 3 Estimated Outcome Amount: $7,608	Year 4 Estimated Outcome Amount: $12,209	Year 5 Estimated Outcome Amount: $29,195
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $55,576			

Title of Outcome Measure (Improvement Target): IT-1.5 Annual monitoring for patients on persistent medications-anticonvulsant *(Non- standalone measure)*

Unique RHP Outcome Identification Number: 121790303.3.20

Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description:
IT-1.5: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non- standalone measure)*
Percentage of members 18 years of age and older who received at least 180 treatment days for an anticonvulsant during the measurement year and had at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year.

Since we do not have a baseline for patients receiving a serum concentration test during the measurement year, we are proposing the following tiers of improvement:

- If 25-50% of patients on an anticonvulsant are receiving a serum concentration test within one year then our improvements will be 5% in DY3, 10% in DY4 and 15% in DY5 (all over DY2 baseline)
- If 50-75% of patients on an anticonvulsant are receiving a serum concentration test within one year then our improvements will be 5% in DY3, 7% in DY4 and 9% in DY5 (all over DY2 baseline)
- If 75-90% of patients on an anticonvulsant are receiving a serum concentration test within one year then our improvements will be 2% in DY3, 4% in DY4 and 6% in DY5 (all over DY2 baseline)
- If 90% of patients on an anticonvulsant are receiving a serum concentration test within one year then we will not pursue this outcome improvement and will defer to using only IT-1.19 Antidepressant Medication Management (Standalone)

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
        - We will establish our baseline rate. Based on clinician input, we believe about 5% of patients in Baylor Clinics are on an anticonvulsant. We do not have any data on how many of those patients received a serum test in the past year.

Outcome Improvement Targets for each year

- DY3:
    - IT-1.5: Annual monitoring for patients an anticonvulsant (Non-Standalone)
        - Our goal is increase the % of patients that have had a serum concentration test in the past year to 2% or 5% depending on baseline established in DY2
- DY4:
    - IT-1.5: Annual monitoring for patients an anticonvulsant (Non-Standalone)
        - Our goal is increase the % of patients that have had a serum concentration test in the past year to 4%, 5% or 10% depending on baseline in DY2
- DY5:
    - IT-1.5: Annual monitoring for patients an anticonvulsant (Non-Standalone)
        - Our goal is increase the % of patients that have had a serum concentration test in the past year to 6%, 9% or 15% depending on the baseline in DY2

Rationale

Only about 5% of Baylor Clinic patients are on an anticonvulsant medication regimen. This may be because there are no formal behavioral health programs in the Baylor Clinic, it is possible that identification of BH issues is low and utilization of anticonvulsants would increase with an increased emphasis on identifying BH issues. A study in Psychiatric Services found that 50% of patients that were given anticonvulsant prescriptions to treat bipolar disorder were non-adherent.[449] This issue can be resolved by explaining the risks v. benefits for taking an anticonvulsant.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

[449] Sajattovic, M, et. al. Treatment adherence with lithium and anticonvulsant medications among patients with bipolar disorder. *Psychiatric Services*. 58(6):855-63. 2007.

121790303.2.5- Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

121790303.3.20	*3.IT-1.5*	*Annual monitoring for patients on persistent medications-anticonvulsant (Non- standalone measure)*

Baylor Medical Center at Garland	*121790303*
Related Category 1 or 2 Projects:	*121790303.2.5***–** *Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 5% of Baylor Clinic patients take an anticonvulsant. We do not know the rate of monitoring for serum concentration testing.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on an anticonvulsant.*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $3282 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $3282	**Outcome Improvement Target 1** [IT-1.5]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non- standalone measure)* Improvement Target: > 2% of patients 18 years of age and older who received at least 180 treatment days of anticonvulsants during the measurement year and had at least one serum concentration test in the measurement year. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $7608	**Outcome Improvement Target 2** [IT-1.5]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non-standalone measure)* Improvement Target: > 4% of patients 18 years of age and older who received at least 180 treatment days of anticonvulsants during the measurement year and had at least one serum concentration test in the measurement year. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $12,209	**Outcome Improvement Target 3** [[IT-1.5]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non-standalone measure)* Improvement Target: > 6% of patient s18 years of age and older who received at least 180 treatment days of anticonvulsants during the measurement year and had at least one serum concentration test in the measurement year. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $29,195
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $6,564	Year 3 Estimated Outcome Amount: $7,608	Year 4 Estimated Outcome Amount: $12,209	Year 5 Estimated Outcome Amount: $29,195
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $55,576			

Management and Prescription Assistance Program

121776204.3.19	*3.IT-1.4*	*Annual monitoring for patients on persistent medications diuretic (Non- standalone measure)*

Baylor Medical Center at Irving	*121776204*

Related Category 1 or 2 Projects:	*121776204.2.5***–** *Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 33% of Baylor Clinic patients take a diuretic. We do not know the rate of monitoring for serum potassium/creatinine or BUN.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on a diuretic*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $3267 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $3267	**Outcome Improvement Target 1** [IT-1.4]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non- standalone measure)* Improvement Target: > 2% of patient 18 years of age and older who received at least 180 treatment days of diuretics during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $7573	**Outcome Improvement Target 2** [IT-1.4]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non-standalone measure)* Improvement Target: > 4% of patient 18 years of age and older who received at least 180 treatment days of diuretics during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $12,152	**Outcome Improvement Target 3** [IT-1.4]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non-standalone measure)* Improvement Target: > 6% of patient 18 years of age and older who received at least 180 treatment days of diuretics during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $29,060
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $6,534	Year 3 Estimated Outcome Amount: $7,573	Year 4 Estimated Outcome Amount: $12,152	Year 5 Estimated Outcome Amount: $29,060

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $55,319

Title of Outcome Measure (Improvement Target): IT-1.5 Annual monitoring for patients on persistent medications-anticonvulsant *(Non- standalone measure)*
Unique RHP Outcome Identification Number: 121776204.3.20

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description:
IT-1.5: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non- standalone measure)*
Percentage of members 18 years of age and older who received at least 180 treatment days for an anticonvulsant during the measurement year and had at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year.

Since we do not have a baseline for patients receiving a serum concentration test during the measurement year, we are proposing the following tiers of improvement:

- If 25-50% of patients on an anticonvulsant are receiving a serum concentration test within one year then our improvements will be 5% in DY3, 10% in DY4 and 15% in DY5 (all over DY2 baseline)
- If 50-75% of patients on an anticonvulsant are receiving a serum concentration test within one year then our improvements will be 5% in DY3, 7% in DY4 and 9% in DY5 (all over DY2 baseline)
- If 75-90% of patients on an anticonvulsant are receiving a serum concentration test within one year then our improvements will be 2% in DY3, 4% in DY4 and 6% in DY5 (all over DY2 baseline)
- If 90% of patients on an anticonvulsant are receiving a serum concentration test within one year then we will not pursue this outcome improvement and will defer to using only IT-1.19 Antidepressant Medication Management (Standalone)

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
        - We will establish our baseline rate. Based on clinician input, we believe about 5% of patients in Baylor Clinics are on an anticonvulsant. We do not have any data on how many of those patients received a serum test in the past year.

Outcome Improvement Targets for each year

- DY3:

- IT-1.5: Annual monitoring for patients an anticonvulsant (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum concentration test in the past year to 2% or 5% depending on baseline established in DY2

- DY4:
    - IT-1.5: Annual monitoring for patients an anticonvulsant (Non-Standalone)
        - Our goal is increase the % of patients that have had a serum concentration test in the past year to 4%, 5% or 10% depending on baseline in DY2

- DY5:
    - IT-1.5: Annual monitoring for patients an anticonvulsant (Non-Standalone)
        - Our goal is increase the % of patients that have had a serum concentration test in the past year to 6%, 9% or 15% depending on the baseline in DY2

Rationale

Only about 5% of Baylor Clinic patients are on an anticonvulsant medication regimen. This may be because there are no formal behavioral health programs in the Baylor Clinic, it is possible that identification of BH issues is low and utilization of anticonvulsants would increase with an increased emphasis on identifying BH issues. A study in Psychiatric Services found that 50% of patients that were given anticonvulsant prescriptions to treat bipolar disorder were non-adherent.[450] This issue can be resolved by explaining the risks v. benefits for taking an anticonvulsant.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

[450] Sajattovic, M, et. al. Treatment adherence with lithium and anticonvulsant medications among patients with bipolar disorder. *Psychiatric Services*. 58(6):855-63. 2007.

121776204.2.5- Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

121776204.3.20	*3.IT-1.5*	*Annual monitoring for patients on persistent medications-anticonvulsant (Non- standalone measure)*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.2.5***–** *Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*		
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 5% of Baylor Clinic patients take an anticonvulsant. We do not know the rate of monitoring for serum concentration testing.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on an anticonvulsant.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $3267 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $3267	**Outcome Improvement Target 1** [IT-1.5]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non- standalone measure)* Improvement Target: > 2% of patients 18 years of age and older who received at least 180 treatment days of anticonvulsants during the measurement year and had at least one serum concentration test in the measurement year. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $7573	**Outcome Improvement Target 2** [IT-1.5]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non-standalone measure)* Improvement Target: > 4% of patients 18 years of age and older who received at least 180 treatment days of anticonvulsants during the measurement year and had at least one serum concentration test in the measurement year. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $12,152	**Outcome Improvement Target 3** [[IT-1.5]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non-standalone measure)* Improvement Target: > 6% of patient s18 years of age and older who received at least 180 treatment days of anticonvulsants during the measurement year and had at least one serum concentration test in the measurement year. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $29,060
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $6,534	Year 3 Estimated Outcome Amount: $7,573	Year 4 Estimated Outcome Amount: $12,152	Year 5 Estimated Outcome Amount: $29,060
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $55,319			

Title of Outcome Measure (Improvement Target): IT-1.19 Antidepressant Medication Management *(Standalone measure)*
Unique RHP Outcome Identification Number: 121790303.3.21

Performing Provider Name/TPI: Baylor Medical Center at Garland/121790303

Outcome Description:
IT-1.19: Antidepressant Medication Management - NQF 0105237 *(Standalone measure)*

Numerator:

A) Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

B) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period.Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).

Denominator: Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year.
***Note** because this project will occur in an ambulatory setting, we will need to modify the denominator to more accurately measure the impact of this outcome. Instead of members discharged from an acute inpatient setting with a mental health diagnosis (as many of these patients may not come to a Baylor Clinic), we propose changing the denominator to all patients at a Baylor Clinic on the Baylor Medical Center at Garland campus with an identified mental health issue and on a psychiatric medication.

We do not have an established baseline of tracking patients who received Acute Phase/Continuation phase treatment with antidepressants. Based on the baseline analysis in DY2, we may have to reevaluate or modify this outcome.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline rates
    - We will establish our baseline rate. Based on clinician input, we believe about 20% of patients in Baylor Clinics are on an antidepressant. We do not have any data on how many of those patients received acute/continuous phase treatment.

Outcome Improvement Targets for each year

- DY3:
  - IT-1.19: Antidepressant Medication Management (Standalone)
    - Our goal is increase the % of patients that have are engaged in Effective Acute Phase Treatment by 5%
    - Our goal is to increase the % of patients that have engaged in Effective Continuous Phase Treatment by 3%
- DY4:
  - IT-1.19: Antidepressant Medication Management (Standalone)
    - Our goal is increase the % of patients that have are engaged in Effective Acute Phase Treatment by 10%
    - Our goal is to increase the % of patients that have engaged in Effective Continuous Phase Treatment by 5%
- DY5:
  - IT-1.19: Antidepressant Medication Management (Standalone)
    - Our goal is increase the % of patients that have are engaged in Effective Acute Phase Treatment by 15%
    - Our goal is to increase the % of patients that have engaged in Effective Continuous Phase Treatment by 7%

Rationale

Approximately 20% of Baylor Clinic patients on an antidepressant medication regimen. According to the Community Health Needs Assessment, behavioral health is a major issue in the region. The top 10 utilizers in the region had BH related issues.[451] While antidepressants are not the solution to this problem, managing depression can have other positive ancillary effects on clinical adherence and avoidance of BH exacerbations. This outcome enforces both short and long term adherence to this drug in order to avoid adverse events for patients. An article in the Journal of Clinical Psychiatry, evidence was found "…to support collaborative care interventions in a primary care setting demonstrated significant improvements in antidepressant drug

[451] RHP 9 Community Health Needs Assessment

adherence during the acute and continuous phase of treatment and were associated with clinical benefit, especially in patients suffering from major depression and were prescribed adequate dosages of antidepressant medication.[452]" Our project supports this methodology.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.2.5- Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

[452] Vergouwen, AC, et. al. Improving adherence to antidepressants: a systematic review of interventions. *J Clin Psychiatry.* 64(12):1415-20. 2003.

121790303.3.21	*3.IT-1.19*	*Antidepressant Medication Management (Non- standalone measure)*		
Baylor Medical Center at Garland				*121790303*
Related Category 1 or 2 Projects:	*121790303.2.5– Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*			
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 20% of Baylor Clinic patients take an anticonvulsant. We do not know the rate of monitoring for serum concentration testing.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on an antidepressant.*			
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $$3282 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $3282		**Outcome Improvement Target 1** [IT-1.19]: Antidepressant Medication Management - NQF 0105237 *(Standalone measure)* Improvement Target: • Increase the % of patients that have are engaged in Effective Acute Phase Treatment by 5% • Increase the % of patients that have engaged in Effective Continuous Phase Treatment by 3% Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment: $7608	**Outcome Improvement Target 2** [IT-1.19]: Antidepressant Medication Management - NQF 0105237 *(Standalone measure)* Improvement Target: • Increase the % of patients that have are engaged in Effective Acute Phase Treatment by 10% • Increase the % of patients that have engaged in Effective Continuous Phase Treatment by 5% Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $12,209	**Outcome Improvement Target 3** [IT-1.19]: Antidepressant Medication Management - NQF 0105237 *(Standalone measure)* Improvement Target: • Increase the % of patients that have are engaged in Effective Acute Phase Treatment by 15% • Increase the % of patients that have engaged in Effective Continuous Phase Treatment by 7% Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $29,195
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $6,564		Year 3 Estimated Outcome Amount: $7,608	Year 4 Estimated Outcome Amount: $12,209	Year 5 Estimated Outcome Amount: $29,195
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $55,576				

Title of Outcome Measure (Improvement Target): IT-1.7 Controlling High Blood Pressure (NCQA-HEDIS, 2012, NQF 0018) (Standalone)

Unique RHP Outcome Identification Number: 121776204.3.1

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description

IT-1.7: Controlling high blood pressure *(Standalone measure)*

- Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year
- Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension

As one of our primary care metrics we chose blood pressure. As high blood pressure is a prerequisite to many other chronic illnesses and serious medical conditions, getting BP under control with proper PCP supervision, medications and regular visits can help patients' quality of life and overall health.

By the end of the waiver, our goal is to have > 75.5% (or a total of 7.5% improvement over baseline) of patients who are patients of the Baylor Clinics at Baylor Medical Center at Irving to have good blood pressure control (< 140/80 mmHg). This is an improvement of 7.5% over baseline. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
        - We will confirm and establish our baseline. Baylor currently tracks BP control and uses a threshold of <130/80 mmHg for patients that have hypertension. Based on our current data, 71.4% of patients with hypertension have controlled BP (130/80 mmHg

Improvement Milestones

- DY3:
    - [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)
        - Our goal is increase the % of patients that have BP control (140/80 mmHg) to 72.8% (or 1.4% improvement over established baseline)
- DY4:
    - IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)
        - Our goal is increase the % of patients that have BP control (140/80 mmHg) to 74.2% (or 2.8% improvement over baseline)
- DY5:
    - [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)
        - Our goal is increase the % of patients that have BP control (140/80 mmHg) to 75.5% (or 4.1% improvement over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Controlling high blood pressure is essential in avoiding heart attacks, stroke, heart failure and a multitude of other diseases and complications. Through medication management, proper primary care attention and education, patients can achieve better blood pressure control in the outpatient setting. In Region 9, Hypertension was identified as one of the top 5 most prevalent diseases in the area for ED visits.[453] A recent article in the New York Times suggested that hypertensive complications can be especially deadly in the African American population, who make up 22.5% of the RHP 9 population[454] and 12.3% of the Irving population.[455] Blood pressure is a standard metric that all Baylor Clinics monitor and regulate. Patients who are uncontrolled will receive the attention they need to get their hypertension under control. Patients will receive medication management, lifestyle management techniques and education about their illness in this clinic PCMH setting. Our metrics and milestones are designed to increase improvement in BP control for the target population.

[453] RHP 9 Community Health Needs Assessment
[454] http://health.nytimes.com/health/guides/disease/hypertension/complications.html
[455] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/4829000.html

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

121776204.3.1	*3.IT-1.7*	*Controlling high blood pressure*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.1.1- Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Irving had 71.4% of patients with controlled BP (130/80 mmHg)* ***Target Population:*** *Underserved/uninsured patients in Irving with uncontrolled BP (>140/80 mmHg)*		
Year 2 (10/1/2012 – 9/30/2013)	**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-1.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 7,100 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $7,100	**Outcome Improvement Target 1** [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone) Improvement Target: > 72.8% (or 1.4% improvement over baseline) of patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $16,459	**Outcome Improvement Target 2** [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone) Improvement Target: > 74.2% (or 2.8% improvement over baseline) of patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 26,411	**Outcome Improvement Target 3** [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone) Improvement Target: > 75.5% (or 4.1% improvement over baseline) of patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 63,157
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $14,200	Year 3 Estimated Outcome Amount: $16,459	Year 4 Estimated Outcome Amount: $26,411	Year 5 Estimated Outcome Amount: $ 63,157
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 120,227			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores (Standalone measure)

1) Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Clinic Wait Times

Unique RHP Outcome Identification Number: 121776204.3.2

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description

IT-6.1: 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. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(1) are getting timely care, appointments, and information; ***(Standalone measure)***
(2) how well their doctors communicate; ***(Standalone measure)***
(3) patient's rating of doctor access to specialist; ***(Standalone measure)***
(4) patient's involvement in shared decision making, and ***(Standalone measure)***
(5) patient's overall health status/functional status. ***(Standalone measure)***

Patient satisfaction is an important part of overall treatment and encourages participation and compliance of patients' in their own care. For this metric we will be measuring is to improve the satisfaction scores in regards to clinic wait times.

By the end of the waiver, our goal is to have the patients at Baylor Clinics on the Baylor Medical Center at Irving campus to attain a patient satisfaction score of 84.8% (or total 2.5% improvement over baseline) on the survey question related to wait time to appointment satisfaction. This falls under metric (1)- patients are getting timely care, appointments and information of 3.6.1, option (1). Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Although the Baylor Clinic at Baylor Medical Center at Irving is at a 82nd percentile score of patients satisfaction related to this particular metric, we believe there is still opportunity to improve and that with any incremental gain in patient satisfaction equates to better compliance and outcomes for our patients. The baseline percentile score of 82.3% is equivalent to only a 43 percentile score nationally, which also presents an opportunity to improve for this Baylor Clinic. By maintaining high standards and enforcing metrics around satisfaction for our staff, we will continue to pursue high patient satisfaction scores in our Baylor Clinics.

Process Milestones:

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - We will confirm and establish our baseline. Currently, the Baylor Clinics at Baylor Medical Center at Irving are at 82.3% satisfaction with clinic wait times

Improvement Milestones:

- DY3:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - Our goal is increase the % of patient satisfaction related to wait times to 83.2% (or 0.9% improvement over baseline)
- DY4:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - Our goal is increase the % of patient satisfaction related to wait times to 84.0% (or 1.7% improvement over baseline)
- DY5:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - our goal is increase the % of patient satisfaction related to wait times to 84.8% (or 2.5% improvement over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Data from Press Ganey Associates in 2007 has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease[456]. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less physician/staff time, reducing length of visits and wait times for the overall practice. Baylor Clinics have historically had high performance in all measures related to

[456] Drain, M., & Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

patient satisfaction; however there is opportunity for improvement. This outcome has an impact on the region through increasing utilization of outpatient based primary care. If patients are satisfied, they will continue to come to their appointments, stay healthier and stay out of the ED. We anticipate that we will be able to raise patient satisfaction in the domains mentioned below through the Baylor Clinic PCMH model.

1) Patients are getting timely care, appointments and information (Standalone measure): We will measure this particular metric through monitoring and improving the survey question around improving clinic wait times for patients

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

121776204.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.1.1-*. Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Irving had a satisfaction rate related to clinic wait times of 82.3%* ***Target Population:*** *Underserved/uninsured patients in a Baylor Clinic PCMH in Irving*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 5,325	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 83.2% (or 0.9% improvement over baseline) satisfaction rate with clinic wait times will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 6,172	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 84.0% (or 1.7% improvement over baseline) satisfaction with clinic wait times will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 9,904	**Outcome Improvement Target 3** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 84.8% (or 2.5% improvement over baseline) satisfaction with clinic wait times will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 23,684
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 5,325	Year 3 Estimated Outcome Amount: $ 6,172	Year 4 Estimated Outcome Amount: $ 9,904	Year 5 Estimated Outcome Amount: $ 23,684
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 45,085			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores (**Standalone measure)**

2) Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Response Time to Patient Phone Calls

Unique RHP Outcome Identification Number: 121776204.3.3

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description

IT-6.1: 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. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(1) are getting timely care, appointments, and information; ***(Standalone measure)***
(2) how well their doctors communicate; ***(Standalone measure)***
(3) patient's rating of doctor access to specialist; ***(Standalone measure)***
(4) patient's involvement in shared decision making, and ***(Standalone measure)***
(5) patient's overall health status/functional status. ***(Standalone measure)***

Patient satisfaction is an important part of overall treatment and encourages participation and compliance of patients' in their own care. For this metric we will be measuring improvement in the responsiveness to patient phone calls in a timely manner.

By the end of the waiver, our goal is to have the Baylor Clinic at Baylor Medical Center at Irving obtain a patient satisfaction score of 89.7% (or a total of 1.7% improvement over baseline) on the survey question related to patient phone calls being returned in a timely fashion. This falls under metric (2) Patients are getting timely care, appointments and information of 3.6.1, option (2). Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Although the Baylor Clinic at Baylor Medical Center at Irving is at a 88th percentile score of patients satisfaction related to this particular metric, we believe there is still opportunity to improve and that with any incremental gain in patient satisfaction equates to better compliance and outcomes for our patients. The baseline percentile score of 88.0% is equivalent to a 69 percentile score nationally, which also presents an opportunity to improve for this Baylor Clinic. By maintaining high standards and enforcing metrics around satisfaction for our staff, we will continue to pursue high patient satisfaction scores in our Baylor Clinics.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - We will confirm and establish our baseline. Currently, the Baylor Clinics at Baylor Medical Center at Irving are at 88.0% satisfaction with patients receiving a response to their phone calls in a timely manner

Improvement Milestones

- DY3:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - Our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 88.6% (or minimum of 0.6% improvement over baseline)
- DY4:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - Our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 89.2% (or minimum of 1.2% improvement over baseline)
- DY5:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - Our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 89.7% (or a minimum of 1.7% improvement over baseline)

Although the Baylor Clinic at Baylor Medical Center at Irving is at a 88th %ile score of patients satisfaction related to this particular metric, we believe there is still opportunity to improve and that with any incremental gain in patient satisfaction equates to better compliance and outcomes for our patients. By maintaining high standards and enforcing metrics around satisfaction for our staff, we will continue to pursue high patient satisfaction scores in our Baylor Clinics.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Data from Press Ganey Associates in 2007 has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease[457]. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less physician/staff time, reducing length of visits and wait times for the overall practice. Baylor Clinics have historically had high performance in all measures related to patient satisfaction; however there is opportunity for improvement. This outcome has an impact on the region through increasing utilization of outpatient based primary care. If patients are satisfied, they will continue to come to their appointments, stay healthier and stay out of the ED. We anticipate that we will be able to raise patient satisfaction in the domains mentioned below through the Baylor Clinic PCMH model.

2) *Patients are getting timely care, appointments and information (Standalone measure): We will measure this particular metric through monitoring and improving the survey question around response times to patient phone calls*

Outcome Measure Valuation:

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

[457] Drain, M., & Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

121776204.3.3	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.1.1-Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Irving had a satisfaction rate related to clinic response to patient phone call of 88.0%* ***Target Population:*** *Underserved/uninsured PCMH patients of the Baylor Clinic in the Irving area*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 5,325	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 88.6% (or a minimum of 0.6% improvement over baseline) satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 6,172	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 89.2% (or minimum of 1.2% improvement over baseline) satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 9,904	**Outcome Improvement Target 3** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 89.7% (or 1.7% improvement over baseline) satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 23,684
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 5,325	Year 3 Estimated Outcome Amount: $ 6,172	Year 4 Estimated Outcome Amount: $ 9,904	Year 5 Estimated Outcome Amount: $ 23,684
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 45,085			

Title of Outcome Measure (Improvement Target): IT-12.1 Breast Cancer Screening (Non-Standalone)

Unique RHP Outcome Identification Number: 121776204.3.4

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description

IT-12.1: Breast Cancer Screening (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

By the end of the waiver, our goal is to have > 50.7% (or total of 8.2% improvement over baseline) of women ages 40-69 who are patients of the Baylor Clinics at Baylor Medical Center at Irving to have a breast cancer screening. This is an improvement of 8.2% over baseline. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones:

DY2:

P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

We will confirm and establish our baseline. The Baylor Clinic at Baylor Medical Center at Irving is at a 42.5% screening rate for women between 40-69 years old

Improvement Milestones

DY3:

[IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone)

Our goal is increase the % of patients have had a breast cancer screen to at least 45.4% (or 2.9% improvement over baseline)

DY4:

[IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone)

Our goal is increase the % of patients have had a breast cancer screen to at least 48.1% (or 5.6% improvement over baseline)

DY5:

[IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone)

Our goal is increase the % of patients have had a breast cancer screen to at least 50.7% (or 8.2% improvement over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

In Dallas County, 23.7/100,000 women die from breast cancer, with a higher rate of 37/100,000 for African American women.[458] According to the Healthy North Texas community dashboard, 76.1% of women in the Dallas-Plano-Irving areas received a mammogram, leaving opportunities to increase this rate for the underserved population. There is room for improvement with this metric to screen more women and utilize early detection methods for breast cancer.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

[458] Healthy People North Texas: http://www.healthyntexas.org

121776204.3.4	*3.IT-12.1*	*Breast Cancer Screening*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.1.1-Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Irving had only 42.5% of women over the age of 40 receive a breast cancer screen* ***Target Population:*** *Underserved women in Dallas County (Irving) that are over the age of 40*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $8,875	**Outcome Improvement Target 1** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone) Improvement Target: > 45.4% (or 2.9% improvement over baseline) of women over the age of 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $10,287	**Outcome Improvement Target 2** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone) Improvement Target: > 48.1% (or 5.6% improvement over baseline) of women over the age of 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 16,507	**Outcome Improvement Target 3** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone) Improvement Target: > 50.7% (or 8.2% improvement over baseline) of women over the age of 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 39,473
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 8,875	Year 3 Estimated Outcome Amount: $ 10,287	Year 4 Estimated Outcome Amount: $ 16,507	Year 5 Estimated Outcome Amount: $ 39,473
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 75,142			

Title of Outcome Measure (Improvement Target): IT-12.5 Other USPSTF-endorsed screening outcome measures (Non-Standalone): Influenza Vaccination Rate

Unique RHP Outcome Identification Number: 121776204.3.5

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description

IT-12.5: Other USPSTF-endorsed screening outcome measures

As part of primary care, the influenza vaccine is a simple, cost effective way for patients to protect themselves from the flue and other potential clinical exacerbations.

By the end of the waiver, our goal is to have > 66.0% (or 5.7% improvement over baseline) of patients of Baylor Clinic patients over the age of 18 receive an influenza vaccination. This is an improvement of 5.7% over baseline. . Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will confirm and establish our baseline. The Baylor Clinics at Baylor Medical Center at Irving are at a 60.3% rate for patients over the age of 18 that have received an influenza vaccine in the past 12 months

Improvement Milestones

- DY3:
    - IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone)
        - Our goal is increase the % of patients >18 years old that have had an influenza vaccination in the past 12 months to 62.3% (or 2% improvement over baseline)
- DY4:
    - IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone)
        - Our goal is increase the % of patients >18 years old that have had an influenza vaccination in the past 12 months to 64.2% (or 3.9% improvement over baseline)

- DY5:
    - IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone)

        - Our goal is increase the % of >18 years old that have had an influenza vaccination in the past 12 months to 66.0% (or 5.7% improvement over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

In Dallas County, only 65% of individuals over the age of 18 received an influenza vaccination in the past 12 months.[459] The rate of influenza vaccinations in the Region is quite low and there is an opportunity to increase the number in the target population that receive this basic vaccination in order to prevent exacerbations of health issues, reduce the prevalence of influenza and prevent ED visits related to influenza that can otherwise be handled in an outpatient setting.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

[459] Healthy People North Texas: http://www.healthyntexas.org

121776204.3.5	*IT-12.5*	*Other USPSTF-endorsed screening outcome measures (Influenza Vaccination)*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.1.1- Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Irving had 60.3% of patients over the age of 18 receive an influenza vaccination* ***Target Population:*** *Underserved/uninsured patients 18 years and older in Dallas County (Irving)*		
Year 2 (10/1/2012 – 9/30/2013)	**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-1.1] Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete planning processes for primary care expansion Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 8,875	**Outcome Improvement Target 1** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone) Improvement Target: > 62.3% (or 2% improvement over baseline) of patients over the age of 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 10,287	**Outcome Improvement Target 2** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone) Improvement Target: > 64.2% (or 3.9% improvement over baseline) of patients over the age of 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 16,507	**Outcome Improvement Target 3** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone) Improvement Target: > 66.0% (or 5.7% improvement over baseline) of patients over the age of 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 39,473
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 8,875	Year 3 Estimated Outcome Amount: $ 10,287	Year 4 Estimated Outcome Amount: $ 16,507	Year 5 Estimated Outcome Amount: $ 39,473
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 75,142			

Title of Outcome Measure (Improvement Target): IT-11.1 Improvement in Clinical Indicator in identified disparity group. Improvement in Asthma Metrics

Unique RHP Outcome Identification Number: 121776204.3.6

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description

The disparity group for this metric is the underserved/uninsured population in Dallas County that has uncontrolled Asthma.

IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider *(Standalone measure)*

- Numerator: Number of asthma opportunities completed/fulfilled
- Denominator: Asthma appropriate opportunities x number of asthma patients

By the end of the waiver, our goal is to have achieved a 30.4% (or 11.6% improvement over baseline) percent of opportunities achieved for the Baylor Health Care System Asthma Percent of Opportunity Achieved (POA). This is an aggressive 11.6% improvement target over baseline.

At Baylor Health Care System, we have a standard Asthma POA which consists of: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. We measure this yearly for our Asthma patients and calculate POA by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population.

POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in asthma management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their asthma patients than in the prior reporting period.

For an illustrative example: For Asthma- there are 4 potential opportunities (i.e. metrics) per patient (1) documentation of Action/Mgmt Plan, 2) Severity Assessment, 3) Controller Therapy for those who are eligible, and 4) Spirometry within last two years). The denominator would be # of patients x 4. So, for example, if there are 10 patients x 4 opportunities each = 40 opportunities to be achieved. If, in the course of the year, only 30 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 30/40=75%. To

achieve a 10% improvement in POA, we would have to have completed at least 34/40 opportunities to get at 85% achievement.
Our milestones include the following:

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that 18.8% POA was achieved for Asthma patients

Outcome Improvement Targets for each year

- DY3:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Asthma Percent of Opportunities Achieved)
        - Our goal is to increase the POA % for Asthma patients to 22.9% (or 4.1% improvement over baseline)
- DY4:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Asthma Percent of Opportunities Achieved)
        - Our goal is to increase the POA % for Asthma patients to 26.7% (or 7.9% improvement over baseline)
- DY5:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Asthma Percent of Opportunities Achieved)
        - Our goal is to increase the POA % for Asthma patients to 30.4% (or 11.6% improvement over baseline)

In order to meet these improvements, primary care and specialists in the community will have to work together to meet these goals. We feel that Pulmonologists should handle more complex cases but also use this opportunity to help educate the underserved population (especially Hispanics and African Americans) about the importance of screenings and prevention.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Metrics selected were based on historical data from similar programs with specialty care providers that showed material improvement in a 2-3 year time period.

We plan on measuring the improvement in Asthma for Baylor Clinic patients that receive care from a specialist. At Baylor Health Care System, we have a standard Asthma Percent of

Opportunities Achieved which consists of: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. We feel that this measure is a comprehensive way to measure the patients with Asthma in the Baylor Clinic and manage their condition holistically.

Asthma affects about 19.6% of the Dallas County population and had approximately 1158 cases of hospitalization in 2010[460]. According to the Office of Minority Health, African Americans were 30% more likely to have Asthma than non-Hispanic whites and were three times more likely to die from an Asthma related issue than non-Hispanic whites. African Americans make up 12.3% of the Irving population.[461] Hispanics are 30% more likely to visit the hospital for Asthma than non-Hispanic whites.[462] Hispanics comprise 41.1% of the Irving population.[463]

A study by Meng, Leung, et. al found that patients with Asthma that saw a specialist had higher rates of compliance because specialists were more likely to identify the disease and follow national guidelines and protocols to treat these patients leading to better quality outcomes and long(er) term control[464]. Making the pulmonologist a part of our Asthma patients' care team will help to avoid exacerbations, prevent complications and reduce hospitalizations.
Many of the underserved patients in the region require specialty care related to chronic diseases. Lack of timely access to this needed care, often results in clinical exacerbations and worsening of their health conditions that can be avoided or lessened through improved access. A study conducted in 2010 by Bellinger, et. al confirmed that minority and underserved populations not only receive less care but access to care is mitigated by physician referral, geographic location and insurance type.[465]

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or

[460] Healthy People North Texas: http:///www.healthyntexas.org
[461] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/4829000.html
[462] Office of Minority Health: http://www.minorityhealth.hhs.gov
[463] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/4829000.html
[464] Meng YY, Leung KM, Berkbigler D, Halbert RJ. Compliance with US asthma management guidelines and specialty care: a regional variation or national concern? J Eval Clin Pract. 1999 May;5(2):213-21.
[465] Bellinger, JD, Hassan, RM, et.al. Specialty care use in US patients with chronic diseases. Int J. Envion. Res Public Health 2010, 7, 975-990.

diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.1.2- Improve Access to Specialty Care-Expand Specialty Care Services

121776204.3.6	*3.IT-11.1*	*Improvement in Clinical Indicator in identified disparity group-Asthma management in underserved/uninsured population*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.1.2- Improve Access to Specialty Care-Expand Specialty Care Services*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Irving Medical Center had achieved 18.8% of Asthma POA for their patients* ***Target Population:*** *Underserved/uninsured patients in Dallas County (Irving) with uncontrolled Asthma*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports/agreements with specialists Process Milestone 1 Estimated Incentive Payment *(maximum amount): 11,833*	**Outcome Improvement Target 1** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 22.9% (or 4.1% improvement over baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*: $20,574*	**Outcome Improvement Target 2** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 26.7% (or 7.9% improvement over baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $33,014	**Outcome Improvement Target 3** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 30.4% (or 11.6% improvement over baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*: $78,946*
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $11,833	Year 3 Estimated Outcome Amount: $20,574	Year 4 Estimated Outcome Amount: $33,014	Year 5 Estimated Outcome Amount: $78,946
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 144,367			

Title of Outcome Measure (Improvement Target): IT-12.2 Cervical Cancer Screening (HEDIS 2012) (Non-Standalone Measure)

Unique RHP Outcome Identification Number: 121776204.3.7

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description

IT-12.2: Cervical Cancer Screening (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.

As part of preventive care and screenings, cervical cancer screening is a standard practice that PCP/PCMHs provide for their patients. Education and regular exams can be the difference between early detection and death. By the end of the waiver, our goal is to have > 73.3% (or 4.4% improvement over baseline) of patients who are Baylor Clinic at Baylor University Medical Center be screened for Cervical Cancer. This is a 4.4% improvement over baseline. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that 72.2% of patients at the Baylor Clinic at Baylor Medical Center at Irving have had a Cervical Cancer screening

Outcome Improvement Targets for each year

- DY3:
    - IT-12.2: Cervical Cancer Screening
        - Our goal is increase the % of patients that have received a Cervical Cancer screening to at least 73.6% (or 1.4% improvement over baseline)
- DY4:
    - IT-12.2: Cervical Cancer Screening

        - Our goal is increase the % of patients that have received a Cervical Cancer screening to at least 74.9% (or 2.7% improvement over baseline)
- DY5:
    - IT-12.2: Cervical Cancer Screening
        - Our goal is increase the % of patients that have received a Cervical Cancer screening to at least 76.2% (or 4% improvement over baseline)

In order to meet these improvements, primary care and specialists in the community will have to work together to meet these goals. We feel that OB/GYNs should handle more complex cases but also use this opportunity to help educate underserved women in Irving about the importance of screenings and prevention.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Metrics selected were based on historical data from similar programs with specialty care providers that showed material improvement in a 2-3 year time period

In Dallas County approximately the incidence rate of cervical cancer is 9.7 per 100,000.[466] According to the National Cancer Institute, African American women are more likely to be diagnosed with cervical cancer and Hispanic women have the highest cervical cancer incidence rate amongst all women.[467] In Irving, the African American population comprises 12.3% of the population, and Hispanics comprise 41.1%.[468] There is opportunity to increase the screenings in the minority population through engaging OB/GYNs to provide screenings and education for this population. Additionally, these specialists can provide the advanced screenings and education that would not be available in a PCP/PCMH setting.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or

[466] Healthy People North Texas: http://www.healthyntexas.org
[467] National Cancer Institute: http://www.cancer.gov
[468] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/4829000.html

diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.1.2- Improve Access to Specialty Care-Expand Specialty Care Services

121776204.3.7	*3.IT-12.2*	*Cervical Cancer Screening*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.1.2*- Improve Access to Specialty Care-Expand Specialty Care Services		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Irving had a screening rate of 72.2%* ***Target Population:*** *Underserved/uninsured women between the ages of 21-64 in Irving*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports/agreements with specialists Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $11,833	**Outcome Improvement Target 1** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 73.6% (or 1.4% improvement over baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $10,287	**Outcome Improvement Target 2** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 74.9% (or 2.7% improvement over baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $16,507	**Outcome Improvement Target 3** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 76.2% (or 4% improvement over baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $39,473
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $11,833	Year 3 Estimated Outcome Amount: $10,287	Year 4 Estimated Outcome Amount: $16,507	Year 5 Estimated Outcome Amount: $39,473
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $78,100			

Title of Outcome Measure (Improvement Target): IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-Standalone Measure)

Unique RHP Outcome Identification Number: 121776204.3.8

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description

IT-12.3 Colorectal Cancer Screening (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.

By the end of the waiver, our goal is to have > 48.3% (or a total of 8.6% improvement over baseline) of patients who are Baylor Clinic patients at Baylor Medical Center at Irving be screened for Colorectal Cancer. This is an improvement of 8.6% over baseline.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that only 39.7% of patients at the Baylor Clinic at Baylor Medical Center at Irving have had a Colorectal Cancer Screening

Outcome Improvement Targets for each year

- DY3:
  - IT-12.3 Colorectal Cancer Screening
    - Our goal is increase the % of patients that have received a Colorectal Cancer screening to at least 42.7% (or 3% improvement over baseline)
- DY4:
  - IT-12.3 Colorectal Cancer Screening

        - Our goal is increase the % of patients that have received a Colorectal Cancer screening to at least 45.6% (or 5.9% improvement over baseline)

- DY5:
    - IT-12.3 Colorectal Cancer Screening
        - Our goal is increase the % of patients that have received a Colorectal Cancer screening to at least 48.3% (or 8.6% improvement over baseline)

In order to meet these improvements, primary care and specialists in the community will have to work together to meet these goals. We feel that Gastroenterologists should handle more complex cases but also use this opportunity to help educate underserved adults about the importance of screenings and prevention. The Baylor Clinic is currently only at a 39% completion rate and will need the help of their specialist partners to meet these goals.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Metrics selected were based on historical data from similar programs with specialty care providers that showed material improvement in a 2-3 year time period

In Dallas County less than 60% of individuals 50 and over have had a sigmoidoscopy or colonoscopy examination. The colorectal cancer incidence rate is 43.3 cases per 100,000 people. 60% of deaths due to colorectal cancer can be avoided.[469] There is a definite need for these services in Dallas County and the Baylor Clinic plans to provide these screenings to a greater number of people. According to the Centers for Disease Control and Prevention, Hispanics and African Americans are less likely to get screened for colorectal cancer and it is often found in the latter stages of the disease as compared to their Caucasian counterparts.[470] In Irving, African Americans comprise 12.3% of the population and Hispanics, 41.1%.[471] There is an opportunity to increase the colorectal cancer screening rates by engaging specialists in the Dallas County area to provide these basic and advanced screenings along with education that is focused on this particular topic.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for

[469] Healthy People North Texas: http://www.healthyntexas.org
[470] Centers for Disease Control and Prevention: http://www.cdc.gov
[471] Census Quick Facts: http://quickfacts.census.gov/qfd/states/48/4829000.html

each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.1.2- Improve Access to Specialty Care-Expand Specialty Care Services

121776204.3.8	*3.IT-12.3*	*Colorectal Cancer Screening*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.1.2*- Improve Access to Specialty Care-Expand Specialty Care Services		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor Medical Center at Irving had a screening rate of 39.7%* ***Target Population:*** *Underserved/uninsured adults between the ages of 50-75 in Dallas County (Irving).*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports/agreements with specialists Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $11,833	**Outcome Improvement Target 1** [IT-12.2]: Colorectal Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 42.7% (or 3% improvement over baseline) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $10,287	**Outcome Improvement Target 2** [IT-12.2]: Colorectal Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 45.6% (or 5.9% improvement over baseline) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $16,507	**Outcome Improvement Target 3** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 48.3% (or 8.6% improvement over baseline) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $39,473
Year 2 Estimated Outcome Amount: $11,833	Year 3 Estimated Outcome Amount: $10,287	Year 4 Estimated Outcome Amount: $16,507	Year 5 Estimated Outcome Amount: $39,473
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $78,100			

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure)

Unique RHP Outcome Identification Number: 121776204.3.9

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Measure Description

IT-1.10 Diabetes care: *HbA1c poor control (>9.0%) (Standalone measure)*

- Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

By the end of the waiver, our goal is to have < 8.8% (or a minimum reduction of 1.5% over baseline) of patients 18-75 years old with diabetes (type 1 or type 2) out of glycemic control (HbA1c >9.0%). This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program. The additional qualifiers for this metric are the following: 1) a patient has been engaged in chronic care management for at least 6 months, 2) Two HbA1c measures will be taken per patient and the most recent HbA1c score will be used for reporting.

One of the outcome measures we have chosen for our chronic care management program is HbA1c performance, as determined by a reduction in poor control, defined as the percent of the population with HbA1c > 9.0%. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish Baseline Rates
        - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that at least 10.3% of patients at the Baylor Clinic at Baylor Medical Center at Irving have an HbA1c > 9.0%

Outcome Improvement Targets for each year

- DY3:
  - IT-1.10: Diabetes Care: HbA1c poor control (> 9.0%)
    - Our goal is to reduce the HbA1c > 9.0% rate to ≤ 9.8% (or 0.5% reduction over baseline)
- DY4:
  - IT-1.10: Diabetes Care: HbA1c poor control (> 9.0%)
    - Our goal is to reduce the HbA1c > 9.0% rate to ≤ 9.3% (or 1% reduction over baseline)
- DY5:
  - IT-1.10: Diabetes Care: HbA1c poor control (> 9.0%)
    - Our goal is to reduce the HbA1c > 9.0% rate to ≤ 8.8% (or 1.5% reduction over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

In Dallas County, more than 11.4% of the population has a diagnosis of Diabetes.[472] Traditionally, the underserved population in Irving does not have access to the necessary medications and supplies to manage their diabetes thus many patients go undiagnosed or have poor glucose control. Lack of proper education coupled with a lack of primary care attention often leads to more severe complications and poor health outcomes for those with diabetes. This project would facilitate timely and appropriate care for those with diabetes and ensure that regular labs and point of care testing is completed to monitor results and make appropriate interventions.

Bodenheimer, et. al, found that patient self management of chronic disease conditions, such as diabetes, that was co-located in a primary care setting led to significant improvement in HbA1c control in patients.[473] A recent of edition of Managed Care found that patients with an HbA1c > 9 had on average almost $5000 worth of hospitalization costs, while those with an HbA1c of < 7 had about $2700 in hospitalization costs[474]. Focusing efforts on improving glycemic control should result in reduced co-morbid conditions and improved complication rates for these

[472] RHP 9 Community Health Needs Assessment

[473] Bodenheimer, T., Lorig, K.., Holman, H., Grumbach, K. Patient Self-management of Chronic Disease in Primary Care *JAMA* (May 15, 2008).

[474] MenzinJ, Korn, J, Cohen, J, et.al Relationship between glycemic control and diabetes related hospital costs in patients with type 1 or type 1 diabetes mellitus. J Manag Care Pharm. 2010; 16(4):264-275.

patients. We expect that at least 5-7% of patients that are seen regularly in a Baylor Clinic will have improved HbA1c levels.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

121776204.3.9	*3.IT-1.10*	*Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure)*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2. An initial data analysis from our E.H.R shows that at least 10.3% of patients at the Baylor Clinic at Baylor Medical Center at Irving have an HbA1c > 9.0%* ***Target Population:*** *Uninsured/undeserved patients in Dallas County (Irving) with an HbA1c > 9.0%*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
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 reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 10,649 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 10,650	**Outcome Improvement Target 1** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure) Improvement Target: ≤ 9.8% (or -0.5% reduction over baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 19,202	Outcome Improvement Target 2 [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure) Improvement Target: ≤ 9.3% (or 1% reduction over baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment: $ 30,812	**Outcome Improvement Target 3** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure) Improvement Target: ≤ 8.8% (or 1.5% reduction over baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 73,683
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):$ 21,299	Year 3 Estimated Outcome Amount: $ 19,202	Year 4 Estimated Outcome Amount: $ 30,812	Year 5 Estimated Outcome Amount: $ 73,683
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 144,996			

Title of Outcome Measure (Improvement Target): IT-1.11 Diabetes Care: BP control (<140/80 mmHg) NQF 0061 (Standalone measure)

Unique RHP Outcome Identification Number: 121776204.3.10

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Measure Description

IT-1.11 Diabetes care: *BP control (<140/80mm Hg)- (Standalone measure)*

- Numerator: Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg.
- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

By the end of the waiver, our goal is to have > 64.8% (or 5.9% improvement over baseline) of patients 18-75 years old with diabetes (type 1 or type 2) under BP control (< 140/80 mmHg). This is a 5.9% improvement over baseline. This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program for at least 6 months.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish Baseline Rates
        - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that at least 58.9% of patients with diabetes at the Baylor Clinic at Baylor Medical Center at Irving have BP less than 130/80 mmHg. At Baylor Medical Center at Irving Medical Center, we have been historically defining uncontrolled BP > 130/80 mmHg, we will have to adjust our tracking for this project.

Outcome Improvement Targets for each year

- DY3:
    - IT-1.11: Diabetes Care: BP control (<140/80 mmHg)
        - Our goal is increase the % of patients in good BP control (<140/80 mmHg) to 61.0% (or 2.1% improvement over baseline) of patients at the Baylor Clinic who have engaged in the chronic care management program
- DY4:

- IT-1.11: Diabetes Care: BP control (<140/80 mmHg)
    - Our goal is increase the % of patients in good BP control (<140/80 mmHg) to 62.9% (or 4% improvement over baseline) of patients at the Baylor Clinic who have engaged in the chronic care management program

- DY5:
    - IT-1.11: Diabetes Care: BP control (<140/80 mmHg)
        - Our goal is have at least 64.8% (or 5.9% improvement over baseline) of patients in good BP control (<140/80 mmHg)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

We will have to review our baseline numbers in DY2. Historically, in our E.H.R we have been tracking BP control as < 130/80 mmHg. In order to meet the requirements of this project, we will have to re-analyze the numbers and re-establish our new baseline.

As part of the standard of care for diabetes management, optimal blood pressure control is an included component of this protocol. At Baylor Health Care System, blood pressure control and management is a required part of the diabetes care bundle in order to avoid other co-morbid conditions such as heart disease and stroke. A 2010 study in the New England Journal of Medicine by Cushman, et. al showed that better and less severe health outcomes related to cardiovascular episodes and stroke were achieved with tight blood pressure control in diabetic patients[475]. Events that would be fatal with higher blood pressure became nonfatal under better blood pressure control in these studies completed. As part of an outpatient, clinic-based protocol, blood pressure control can be achieved in patients who will come to the Baylor Clinic as part of the primary care expansion project.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to

[475] Cushman WC, Evans, GW, et. al Effects of intensive blood pressure control in type 2 diabetes mellitus. N Engl J Med. 2010. Apr 29; 362(17): 1575-85

determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

121776204.3.10	*3.IT-1.11*	*Diabetes Care: BP control (<140/80 mmHg)*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 and redefined as <140/80 mmHg. Currently, we have about 58.9% of our patients that have a BP < 130/80 mmHg at the Baylor Clinic at Baylor Medical Center at Irving.* ***Target Population:*** *Underserved/uninsured diabetic patients with BP >140/80 mmHg in Dallas County (Irving)*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 2,662 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 2,663	**Outcome Improvement Target 1** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Standalone measure) Improvement Target: > 61.0% (or 2.1% improvement over baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 19,202	**Outcome Improvement Target 2** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Standalone measure) Improvement Target: > 62.9% (or 4% improvement over baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 30,812	**Outcome Improvement Target 3** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Standalone measure) Improvement Target: > 64.8% (or 5.9% improvement over baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 73,683
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 5,325	Year 3 Estimated Outcome Amount: $ 19,202	Year 4 Estimated Outcome Amount: $ 30,812	Year 5 Estimated Outcome Amount: $ 73,682
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 129,021			

Title of Outcome Measure (Improvement Target): IT-1.13 Diabetes Care: Diabetes care: Foot exam- NQF 0056

Unique RHP Outcome Identification Number: 121776204.3.11

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Measure Description

IT-1.13 Diabetes care *Foot exam- (Non- standalone measure)*

- 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).

By the end of the waiver, our goal is to have > 80.6% (or 7.2% improvement over baseline) patients 18-75 years old with diabetes (type 1 or type 2) receive a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year(s). This is an improvement of 7.2% over baseline. These improvements are for patients who are Baylor Clinic patients and have engaged in the chronic care management program.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish Baseline Rates
    - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows 73.4% of diabetic patients that are seen by a diabetes educator at the Baylor Clinic at Baylor Medical Center at Irving receive a foot exam
    -

Outcome Improvement Targets for each year

- DY3:
  - IT-1.13: Diabetes Care: Foot exam
    - Our goal is to increase this rate to at least 76.1% of diabetic patients receiving a foot exam (or 2.7% improvement over baseline)
- DY4:
  - IT-1.13: Diabetes Care: Foot exam
    - Our goal is to increase this rate to at least 78.5% of diabetic patients receiving a foot exam (or 5.1% improvement over baseline)

- DY5:
    - IT-1.13: Diabetes Care: Foot exam
        - Our goal is to increase this rate to at least 80.6% of diabetic patients receiving a foot exam (or 7.2% improvement over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

An innovative part of this project is that the educators (CHWs and RN Care Managers) will be able to conduct diabetic foot exams as part of their education session with their patients. This will increase the rate of screening and allow these providers to identify issues such as ulcers and nerve issues earlier and more often. Foot exams are a low cost, highly effective way to avoid costly interventions such as wound care and management, amputations, neuropathy and other complex issues. This is better utilization and management of resources through early identification and prevention of serious diabetes foot related issues. It is recommended by the American Diabetes Association that diabetic patients receive yearly foot exams to determine if there are predisposing factors for ulceration and amputation[476].

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

[476] American Diabetes Association: http://www.ada.org

121776204.3.11	*3.IT-1.13*	*Diabetes Care: Foot Exam*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2. An initial data analysis from our E.H.R shows that about 73.4% of diabetic patients seen by a diabetes educator at the Baylor Clinic at Baylor Medical Center at Irving receive a foot exam* ***Target Population:*** *Underserved/uninsured patients with diabetes in Dallas County (Irving)*		
Year 2 (10/1/2012 – 9/30/2013)	**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-3.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 5,325 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 5,325	**Outcome Improvement Target 1** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Standalone measure) Improvement Target: >76.1% (or 2.7% improvement over baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 4,800	**Outcome Improvement Target 2** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Standalone measure) Improvement Target: >78.5% (or 5.1% improvement over baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 7,703	**Outcome Improvement Target 3** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Standalone measure) Improvement Target: >80.6% (or 7.2% improvement over baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 18,421
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 10,650	Year 3 Estimated Outcome Amount: $ 4,800	Year 4 Estimated Outcome Amount: $ 7,703	Year 5 Estimated Outcome Amount: $ 18,421
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 41,574			

Title of Outcome Measure (Improvement Target): IT-11.1 Improvement in Clinical Indicator in Identified Disparity Group. Clinical indicator to be improved and disparity group to be determined by provider.

Unique RHP Outcome Identification Number: 121776204.3.12

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Measure Description

IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider *(Standalone measure)*

- Numerator: Number of patients with an improved Diabetes POA (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter
- Denominator: Total number of patients with a Behavioral Health intervention/
- encounter

One of the outcome measures we have chosen for our behavioral health program is to improve Baylor's standard diabetes Percent of Opportunities Achieved (POA) which consists of HbA1c, LDL, BP control for patients who have engaged in our behavioral health program. POA is similar in nature to an improvement bundle, but differs slightly in the way it is calculated. Here, we define the disparate population as the underserved individuals in Dallas County (Irving) that have both a diagnosis of diabetes and a behavioral health issue.

By the end of the waiver, our goal is to have > 15% of patients who have had a behavioral health intervention/encounter to have improvement in our Diabetes POA (HbA1c, LDL, BP, etc) that have uncontrolled values for these measures and have an identified behavioral health issue.

- HbA1c < 8%
- LDL < 100
- BP < 130/80 mmHg

Baylor's standard diabetes POA is measured by using percent of opportunities achieved (POA). We plan on measuring the improvement in Diabetes for Baylor Clinic patients that receive behavioral health treatment. The Diabetes POA which consists of: LDL, BP and HbA1c control is measured yearly for our diabetic patients. The POA is calculated by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population. POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in diabetes management POA from 50% to 60%

within a population means the clinic was successful in achieving 10% more processes/targets for their diabetes patients than in the prior reporting period.

For an illustrative example: For Diabetes- there are 3 opportunities (i.e. metrics) per patient (1) A1c < 8, 2) LDL < 100, 3) BP < 130/80 mmHg). The denominator would be # of patients x 3. So, for example, if there are 10 patients x 3 opportunities each = 30 opportunities to be achieved. If, in the course of the year, only 20 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 20/30=67%. To achieve a 10% improvement in POA, we would have to have completed at least 23/30 opportunities to get at 77% achievement.

We define this outcome in the following way:

Numerator: Number of patients with an improved Diabetes POA (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter

Denominator: Total number of patients with a Behavioral Health intervention/ encounter

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish Baseline Rates
    - We will establish a baseline of current status of the Diabetes POA for patients that have a reported behavioral health issue
- DY3:
  - P-2: Establish Baseline Rates
    - We will compare the DY2 baseline rate to results in DY3 to measure change refine data collection processes if necessary

Outcome Improvement Targets for each year

- DY3:
  - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Diabetes Percent of Opportunities Achieved in Behavioral Health patients)
    - We will improve the Diabetes POA for 5% of patients who have had at least one behavioral health intervention/encounter in one year
- DY4:
  - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Diabetes Percent of Opportunities Achieved in Behavioral Health patients)
    - We will improve the Diabetes POA for 10% of patients who have had at least one behavioral health intervention/encounter in one year
- DY5:

- IT-11.1 Improvement in Clinical Indicator in identified disparity group (Diabetes Percent of Opportunities Achieved in Behavioral Health patients
  - We will improve the Diabetes POA for 15% of patients who have had at least one behavioral health intervention/encounter in one year

Rationale

Category 3 metrics for this projects were identified using literature only. Baylor has had no previous experience with a behavioral health program of this nature. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting.

Our main goal by selecting this outcome was to recognize and increase awareness of patients who have co-occurring behavioral health and diabetes health issues. By recognizing this, we believe we can positively impact diabetes outcomes by addressing underlying behavioral health issues that patients may have.

In DY2, we will collect our baseline information about the status of the Diabetes Metrics (HbA1c, LDL, BP) for patients who have a documented behavioral health issue. The problem with this collection is that because this program is new, both patients and clinicians are not actively looking for and documenting behavioral health problems that patients have. As part of our project, we plan to increase screenings using PHQ2/9, GAD-7 and substance abuse tools but until that is implemented, the numbers we will be reporting for baseline will be underreported. Once there is more awareness about the screenings and program, we anticipate that more patients will disclose their behavioral health issue and their providers will also be more aware of these conditions.

We believe if we increase the treatment rates of behavioral health issues, that we will also see an increase in patient compliance rates with other preventive screening/testing and clinical recommendations made by their providers.

In Region 9, there is a 36% increase in average charges per encounter for those individuals with a co-occurring behavioral health issue and chronic disease. 100% of the frequent flyers had a co-occurring mental illness and cost the Region over $26 million dollars.[477]

A recent study conducted in early 2012, by Jeffery Johnson, et. al showed a direct correlation between diabetes and depression. They cited that depression is the most common co-morbid condition present in 15-30% of patients with Type 2 diabetes and less than 50% are recognized as having depression. Depression is associated with poorer self care behaviors, decreased quality of life and substantially higher health care costs. Both diabetes and behavioral health

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issues are prevalent across the region, warranting measurement of the efficacy of a behavioral health program on chronic diseases[478].

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121790303.2.2: Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment

[478] Johnson, JA, Sayah, FA, et.al. Controlled trial of a collaborative primary care team model for patients with diabetes and depression: rationale and design for a comprehensive evaluation. BMC Health Services Research. 2012, 12:358

121776204.3.12	*IT-11.1*	*Improvement in clinical indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider- Diabetes POA improvement*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.2.2- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor Medical Center at Irving will be established in DY2.* ***Target Population:*** *On average, 15-30% of patients with Diabetes have a co-morbid behavioral health diagnosis (usually Depression), which would mean approximately 33,000-66,000 people in the Irving area*		
Year 2 (10/1/2012 – 9/30/2013)	**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 Goal: Complete planning processes for behavioral health program Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 7,987 **Process Milestone 2** [P-2]: Establish baseline rates Metric: Determine current status of patients with co-occurring illnesses Goal: Determine number of patients with out of range Diabetes POA (HbA1c, LDL, BP) that have a documented behavioral health issue	**Process Milestone 3** [P-2]: Establish baseline rates Metric: Compare DY2 baseline assessment of patients with uncontrolled Diabetes POA and documented behavioral health issues to DY3 data period Goal: Determine if more self or clinician reported data around identification of behavioral health issues has an impact on DY2 baseline reporting Data Source: E.H.R Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 9,258 **Outcome Improvement Target 1** [IT-11.1]: Improve Clinical Indicator in identified disparity group. Improvement Target: Improve Diabetes POA (HbA1c, LDL, BP) for at least 5% of patients who have had at least 1 behavioral health encounter/intervention	**Outcome Improvement Target 2** [IT-11.1]: Improve Clinical Indicator in identified disparity group. Improvement Target: Improve Diabetes POA (HbA1c, LDL, BP) for at least 10% of patients who have had at least 1 behavioral health encounter/intervention Numerator: # of patients with improved Diabetes POA Denominator: # of patients with at least 1 behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 39,617	**Outcome Improvement Target 3** [IT-11.1]: Improve Clinical Indicator in identified disparity group. Improvement Target: Improve Diabetes POA (HbA1c, LDL, BP) for at least 15% of patients who have had at least 1 behavioral health encounter/intervention Numerator: # of patients with improved Diabetes POA Denominator: # of patients with at least 1 behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 94,735

121776204.3.12	*IT-11.1*	*Improvement in clinical indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider- Diabetes POA improvement*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.2.2- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor Medical Center at Irving will be established in DY2.* ***Target Population:*** *On average, 15-30% of patients with Diabetes have a co-morbid behavioral health diagnosis (usually Depression), which would mean approximately 33,000-66,000 people in the Irving area*		
Year 2 (10/1/2012 – 9/30/2013)	**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: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 7,987	Numerator: # of patients with improved Diabetes POA Denominator: # of patients with at least 1 behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 9,258		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 15,974	Year 3 Estimated Outcome Amount: $ 18,516	Year 4 Estimated Outcome Amount: $ 39,617	Year 5 Estimated Outcome Amount: $ 94,735
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 168,842			

Title of Outcome Measure (Improvement Target): IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services and treatment) in target population with identified disparity. (**Non-standalone measure**)

Unique RHP Outcome Identification Number: 121776204.3.13

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Measure Description

IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services and treatment) in target population with identified disparity. *(Non-standalone measure)*

- Numerator: patients who are Baylor clinic patient who engage in a behavioral health treatment/intervention
- Denominator: patients who are Baylor clinic patients who are eligible for behavioral health services

One of the outcome measures we have chosen for our behavioral health program is to increase the number of patients in the underserved population who have improved utilization rates for receiving behavioral health treatments/interventions. The subset of the target population that suffers from mental health issues is prevalent in the region. Only 19.8% of underserved patients receive behavioral treatment in the same setting as their primary care[479]. The disparate population that we will be focusing on is the underserved/uninsured patients in Dallas County (Irving) with behavioral health needs.

By the end of the waiver, our goal is to have > 20% of patients who are eligible to participate in the behavioral health program, engage in the program.

We define this outcome in the following way:

- Numerator: patients who are Baylor clinic patient who engage in a behavioral health treatment/intervention
- Denominator: patients who are Baylor clinic patients who are eligible for behavioral health services

The idea of this metric is that by engaging patients in behavioral health treatment/interventions that their subsequent medical care will also improve. Patients who engage are those who have had at least two behavioral health interventions/encounters in the past 12 months. Patients eligible for behavioral health entail those that have 1) been identified through the PHQ2/9, GAD-7 and Substance Abuse screening tools that are in need of intervention, 2) self- identified need or 3) provider/clinician identification of patient need for behavioral health counseling. This Outcome Measure is different than the Improvement Milestone we proposed in our Category 2 Project Table because Outcome Measure 11.3 focuses on utilization of the

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behavioral health service, entailing that an "engaged" patient is one that has had at least two behavioral health encounters/interventions in the past 12 months. The Improvement Milestone in the project table is a volume metric focused on enrolling the patient in a Behavioral Health program. This Outcome Measure takes this one step further by requiring at least two visits in the past 12 months.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish Baseline Rates
    - We will establish a baseline of how many patients have a behavioral health issue (substance abuse, anxiety, depression, other) based on our E.H.R, self-reported or clinician reported status.
- DY3:
  - P-2: Establish Baseline Rates
    - We will compare our DY2 baseline analysis to DY3 to determine if any improvements need to be made to the data collection process and to capture any variances between the two data sets

Outcome Improvement Targets for each year

- DY3:
  - IT-11.3: Improve utilization rates of clinical preventive services
    - We will improve behavioral health treatment rates by 10%
- DY4:
  - IT-11.3: Improve utilization rates of clinical preventive services
    - We will improve behavioral health treatment rates by 15%
- DY5:
  - IT-11.3: Improve utilization rates of clinical preventive services
    - We will improve behavioral health treatment rates by 20%

Rationale

Category 3 metrics for this projects were identified using literature only. Baylor has had no previous experience with a behavioral health program of this nature. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting.

Our main goal by selecting this outcome was to demonstrate increased access and utilization of the behavioral health program we are proposing.

In DY2, we will collect our baseline information about the number of patients who have a behavioral health issue. The problem with this collection is that because this program is new, both patients and clinicians are not actively looking for and documenting behavioral health problems that patients have. As part of our project, we plan to increase screenings using PHQ2/9, GAD-7 and substance abuse tools but until that is implemented, the numbers we will be reporting for baseline will be underreported. Once there is more awareness about the screenings and program, we anticipate that more patients will disclose their behavioral health issue and their providers will also be more aware of these conditions.

We believe if we increase the treatment rates of behavioral health issues, that we will also see an increase in patient compliance rates with other preventive screening/testing and clinical recommendations made by their providers.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.2.2: Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment

121776204.3.13	*3.IT-11.3*	*Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. The disparate population is the underserved/uninsured patients with behavioral health issues.*		
Baylor Medical Center at Irving				*121776204*
Related Category 1 or 2 Projects:		*121776204.2.2: Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:		***Baseline:*** *The baseline for Baylor Medical Center at Irving will be established in DY2.* ***Target Population:*** *The target population in the Dallas county area is over 50,000 underserved individuals in Irving who suffer from a mental illness*		
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 7,987 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 7,987		**Process Milestone 3** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 3 Estimated Incentive Payment: $ 9,258 **Outcome Improvement Target 1** [IT-11.3]: Improve utilization rates of clinical preventive services Improvement Target: Increase rate of patient engagement by 10% Numerator: # of patients engaged in behavioral health treatment/intervention Denominator: # of patients eligible for behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 9,258	**Outcome Improvement Target 2** [IT-11.3]: Improve utilization rates of clinical preventive services Improvement Target: Increase rate of patient engagement by 15% Numerator: # of patients engaged in behavioral health treatment/intervention Denominator: # of patients eligible for behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $19,808	**Outcome Improvement Target 3** [IT-11.3]: Improve utilization rates of clinical preventive services Improvement Target: Increase rate of patient engagement by 20% Numerator: # of patients engaged in behavioral health treatment/intervention Denominator: # of patients eligible for behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 47,368

121776204.3.13	*3.IT-11.3*	*Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. The disparate population is the underserved/uninsured patients with behavioral health issues.*		
Baylor Medical Center at Irving				*121776204*
Related Category 1 or 2 Projects:		*121776204.2.2: Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:		***Baseline:*** *The baseline for Baylor Medical Center at Irving will be established in DY2.* ***Target Population:*** *The target population in the Dallas county area is over 50,000 underserved individuals in Irving who suffer from a mental illness*		
Year 2 (10/1/2012 – 9/30/2013)		**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): $ 15,974		Year 3 Estimated Outcome Amount: $ 18,516	Year 4 Estimated Outcome Amount: $ 19,808	Year 5 Estimated Outcome Amount: $47,368
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $ 101,666				

Title of Outcome Measure (Improvement Target): IT-5.1 Improved Cost Savings: Demonstrate cost savings in care delivery (Non-**Standalone measure**)

Unique RHP Outcome Identification Number: 121776204.3.14

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Measure Description

IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (*Standalone measure for Project 2.5 only. For all other projects –Non- standalone measure)*

- Type of analysis to be determine by provider from the following list: Cost of Illness Analysis, Cost Minimization Analysis, Cost Effectiveness Analysis (CEA), Cost Consequence Analysis, Cost Utility Analysis, Cost Benefit Analysis

By the end of the waiver, our goal is to have > 30% cost savings in health care services utilization (through fewer ED visits and less overall utilization) for patients who have engaged in our care navigation program and have a confirmed appointment with a PCP/PCMH.

One of the outcome measures we have chosen for our care navigation program is to improve cost savings in the healthcare delivery system for those patients that have been served by the care navigation program.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish Baseline Rates
    - In DY2 we will establish a baseline of average cost savings incurred by patients who have been seen by the care navigation program while in the ED and have a confirmed appointment with a PCP/PCMH. We will compare pre and post utilization patterns of enrolled patients to determine the total cost savings incurred (inpatient and outpatient) per patient. For example, if prior to being seen by our care navigation program, a patient's total cost utilization was $10,000 we anticipate that after being connected to the appropriate resource and being seen for an appointment that over the course of 1 year, total costs would decrease by 20% (DY4) to $8,000.

Outcome Improvement Targets for each year

- DY3:
    - IT-5.2: Improved Cost Savings
        - We aim to improve cost savings for those patients that have been 1) seen by our care navigation and program and 2) have a confirmed appointment by 15% using a pre/post analysis of utilization patterns for total cost of care over the course of 1 year
- DY4:
    - IT-5.2: Improved Cost Savings
        - We aim to improve cost savings for those patients that have been 1) seen by our care navigation and program and 2) have a confirmed appointment by 20% using a pre/post analysis of utilization patterns for total cost of care over the course of 1 year
- DY5:
    - IT-5.2: Improved Cost Savings
        - We aim to improve cost savings for those patients that have been 1) seen by our care navigation and program and 2) have a confirmed appointment by 25% using a pre/post analysis of utilization patterns for total cost of care over the course of 1 year

Rationale

In DY2, we plan to do some in depth utilization analysis to determine a baseline of what the cost utilization patterns are for patients seen at Baylor Medical Center at Irving. This, based on our historical experience with similar programs on other campuses, we anticipate a 15%, 20% and 25% cost savings over the subsequent years in total cost of care savings.

The reason we chose this metric is because financial constraints are a main concern for the Region in being able to provide high quality care to the underserved population. Cost savings and effectiveness are a key part of the overall Waiver and require providers to be good stewards of their resources. This metric is appropriate because it emphasizes appropriate utilization of resources and reinforces the concept of cost effectiveness. We plan to measure the cost effectiveness and cost utilization of this project. According to the Texas Medical Association, the cost of treating a condition that could be treated in the doctor's office for $56.21 (including lab and x-ray) costs $193.92 in the Emergency room[480]. This cost differential multiplied by the 443,000 uninsured in Dallas County creates a significant cost to the county and Region.

Outcome Measure Valuation

[480] Texas Medical Association: http://www.texmed.org

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect

121776204.3.14	*3.IT-5.1*	*Improved cost savings: demonstrate cost savings in care delivery*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor Medical Center at Irving will be established in DY2. Typical costs for an inpatient stay for an uninsured patient is $19,400* ***Target Population:*** *Underserved/uninsured patients without a PCP/PCMH in Dallas County (Irving).*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 7,543 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 7,544	**Outcome Improvement Target 1** [IT-5.1]: Improved Cost Savings Improvement Target: For patients that have been seen by the care navigation program, have a confirmed PCP/PCMH appointment, cost savings should be 15% in a pre-post utilization analysis Data Source: E.H.R/Care Navigation database Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 11,658	**Outcome Improvement Target 2** [IT-5.1]: Improved Cost Savings Improvement Target: For patients that have been seen by the care navigation program, have a confirmed PCP/PCMH appointment, cost savings should be 20% in a pre-post utilization analysis Data Source: E.H.R/Care Navigation database Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 18,708	**Outcome Improvement Target 3** [IT-5.1]: Improved Cost Savings Improvement Target: For patients that have been seen by the care navigation program, have a confirmed PCP/PCMH appointment, cost savings should be 25% in a pre-post utilization analysis Data Source: E.H.R/Care Navigation database Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 44,736
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 15,087	Year 3 Estimated Outcome Amount: $ 11,658	Year 4 Estimated Outcome Amount: $ 18,708	Year 5 Estimated Outcome Amount: $ 44,736
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 90,189			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization

Unique RHP Outcome Identification Number: 121776204.3.15

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Measure Description

IT-9.2 ED appropriate utilization *(Standalone measure)*

- Reduce all ED visits (including ACSC)
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)-N/A
- Reduce Emergency Department visits for target conditions
    - Congestive Heart Failure
    - Diabetes
    - End Stage Renal Disease
    - Cardiovascular Disease/Hypertension
    - Behavioral Health/Substance Abuse
    - Chronic Obstructive Pulmonary Disease
    - Asthma

By the end of the waiver, our goal is to have > 35% reduction in inappropriate ED utilization for all causes and > 20% reduction in inappropriate ED utilization for targeted conditions: CHF, Diabetes, ESRD, CVD/Hypertension, Behavioral Health/Substance Abuse, COPD and Asthma

One of the outcome measures we have chosen for our care navigation program is to reduce ED utilization. The protocol mentions three parts to this metric:

4) Reduce all ED visits (including ACSC)
5) Reduce pediatric Emergency Department visits (CHIPRA Core Measure)-*we will not be measuring this outcome as we do not see pediatric patients at Baylor University Medical Center*
6) Reduce ED visits for target conditions
    a. CHF
    b. Diabetes
    c. ESRD
    d. CVD/Hypertension
    e. Behavioral Health/Substance Abuse
    f. COPD
    g. Asthma

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-3: Establish Baseline Rates
        - We will establish a baseline for the aforementioned components of the improvement metric (less #2- pediatric ED visits) and determine the full opportunity for improvement
- DY3:
    - P-3 Establish Baseline Rates
        - We will conduct a comparison between DY2 and DY3 to determine the change in rates for ED utilization and utilization of targeted conditions and determine any seasonality or variations in data collection/trends

Outcome Improvement Targets for each year

- DY3:
    - IT-9.2: ED Appropriate Utilization
        - We aim to reduce all ED visits by 25% and ED visits for targeted conditions by 10%
- DY4:
    - IT-9.2: ED Appropriate Utilization
        - We aim to reduce all ED visits by 30% and ED visits for targeted conditions by 15%
- DY5:
    - IT-9.2: ED Appropriate Utilization
        - We aim to reduce all ED visits by 35% and ED visits for targeted conditions by 20%

Rationale

Baylor Medical Center at Irving sees very few children, thus metric 2 is not applicable to this project. We do not see enough pediatric patients to make a material impact on the ED utilization rate for this population. Historically, we have not tracked the ED utilization for targeted conditions (i.e. CHF, Diabetes, etc), for this type of project thus we do not have a baseline measurement for these specific diseases. We plan to measure these in DY2 and DY3 and target a modest improvement of ED utilization in the subsequent years.

According to the Community Health Needs Assessment of Region 9, 68% of ED visits were preventable/treatable in an outpatient setting[481]. The stakeholder survey conducted amongst performing providers also indicated that there is a significant overuse of emergency department services due to patients' inability to access primary care. This metric is at the heart of the care navigation project we are proposing and will have a direct impact on patients in Dallas County utilizing the ED at a decreased rate. This project uses the popular concept created by Dr. Atul Gawande, referred to as "hot spotting" indicating a focus on finding the high risk/high utilization rates of the ED and determining the root cause for these visits, and then working to remedy those issues[482]. Issues such as transportation, navigation of community and appropriate resources are just two examples that can lead to more effective use of the ED.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect

[481] RHP 9 Community Health Needs Assessment

[482] Gawande, A. The hot spotters: can we lower medical costs by giving the neediest patients better care? The New Yorker. (2011).

121776204.3.15	*3.IT-9.2*	*ED Appropriate Utilization*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.2.3- Establish/Expand a Patient Care Navigation Program-Care Connect*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor Medical Center at Irving will be established in DY2. Based on historical performance of similar programs, ED utilization typically decreased by 30% in the first year.* ***Target Population:*** *Underserved/uninsured patients without a PCP/PCMH that are frequent users of the ED*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 7,542 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 7,543	**Process Milestone 3** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 11,660 **Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED Utilization for All ED Visits by 25% for those patients who have been served by the care navigation program and have a confirmed appointment with the PCP/PCMH Improvement Target: Reduce ED utilization for patients with targeted conditions (CHF, Diabetes, etc) that have been served by the care navigation program and have a confirmed appointment with a PCP/PCMH by 10% Data Source: E.H.R/Care Navigation database Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 11,660	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED Utilization for All ED Visits by 30% for those patients who have been served by the care navigation program and have a confirmed appointment with the PCP/PCMH Improvement Target: Reduce ED utilization for patients with targeted conditions (CHF, Diabetes, etc) that have been served by the care navigation program and have a confirmed appointment with a PCP/PCMH by 15% Data Source: E.H.R/Care Navigation database Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 37,418	**Outcome Improvement Target 3** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED Utilization for All ED Visits by 35% for those patients who have been served by the care navigation program and have a confirmed appointment with the PCP/PCMH Improvement Target: Reduce ED utilization for patients with targeted conditions (CHF, Diabetes, etc) that have been served by the care navigation program and have a confirmed appointment with a PCP/PCMH by 20% Data Source: E.H.R/Care Navigation database Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 89,473
Year 2 Estimated Outcome Amount:: $ 15,085	Year 3 Estimated Outcome Amount: $ 23,320	Year 4 Estimated Outcome Amount: $ 37,418	Year 5 Estimated Outcome Amount: $ 89,473
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 165,296			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life

Unique RHP Outcome Identification Number: 121776204.3.16

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description:
IT-10.1: Quality of Life *(Standalone measure)*
Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.

By the end of the waiver, our goal is to improve the mean score (average change from patient enrollment to most recent survey) on Quality of Life assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 7% over DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will determine the Quality of Life tool that will be used for this outcome
    - P-2: Establish baseline rates
        - We will confirm and establish our baseline. We do not currently utilize Quality of Life surveys. In a transitional care program for the elderly currently in existence at Baylor Health Care System, clinicians site that that Quality of Life indicators such as depression and cognition exams improve over time with home visits.

Outcome Improvement Targets for each year

- DY3:
    - IT-1.10: Quality of Life (Standalone)
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Quality of Life assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 3% over DY2.
- DY4:
    - IT-1.10: Quality of Life (Standalone)

        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Quality of Life assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 5% over DY2.
- DY5:
    - IT-1.10: Quality of Life (Standalone)
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Quality of Life assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 7% over DY2.

Rationale

Quality of Life assessments such as the SF-36 or AQoL measure components such as: illness, independent living, social relationships, physical senses and psychological wellbeing and will be important to measure in the high risk and vulnerable patients we intend to serve.[483] Understanding social and physical attributes of the patient will be essential in determining their feasibility of following protocols and regimens that will optimize their healthcare. We plan on conducting a QOL assessment every 6 months on patients who have been in the program for at least 6 months. Improvement will be measured from the time the patient is enrolled to time of survey administration.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.2.4-Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)

[483] Hawthorne, G. The assessment of quality of life instrument: a psychometric measure of health related quality of life. *Qual Life Res.*8(3):209-24 (1999)

121776204.3.16	*3.IT-10.1*	*Quality of Life*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.2.4***–** *Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)*		
Starting Point/Baseline:	***Baseline:*** *Baseline will be established in DY2. We do not currently track ADL assessments and improvements.* ***Target Population:*** *High risk, vulnerable patients who are unable to access care in an ambulatory care setting. The top 5% of high risk uninsured and Medicaid patients from the 872,000 uninsured in Dallas County.*		

Year 2 (10/1/2012 – 9/30/2013)	**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-1.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports and Quality of Life assessment tool Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $7,368 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $7,368	**Outcome Improvement Target 1** [IT-10.1]: Quality of Life (Standalone) Improvement Target: > 3% improvement in mean Quality of Life scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $17,080	**Outcome Improvement Target** IT-10.1]: Quality of Life (Standalone) Improvement Target: > 5% improvement in mean Quality of Life scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $27,408	**Outcome Improvement Target 3** IT-10.1]: Quality of Life (Standalone) Improvement Target: > 7% improvement in mean Quality of Life scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 65,540
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 14,735	Year 3 Estimated Outcome Amount: $17,080	Year 4 Estimated Outcome Amount: $27,408	Year 5 Estimated Outcome Amount: $65,540
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 124,763			

Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living
Unique RHP Outcome Identification Number: 121776204.3.17
Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description:
IT-10.2: Activities of Daily Living *(Standalone measure)*
Demonstrate improvement in ADL scores, as measured by evidence based and validated assessment tool, for the target population.

By the end of the waiver, our goal is to improve the mean score (average change from patient enrollment to most recent survey) on Activities of Daily Living assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 7% over DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will determine the Activities of Daily Living tool that will be used for this outcome
    - P-2: Establish baseline rates
        - We will confirm and establish our baseline. In a transitional care program for the elderly currently in existence at Baylor Health Care System, clinicians site that ADL improvement in the elderly population improves where patients go from partial dependence to independence.

Outcome Improvement Targets for each year

- DY3:
    - IT-10.2: Activities of Daily Living *(Standalone measure)*
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Activities of Daily Living assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 3% over DY2.
- DY4:
    - IT-10.2: Activities of Daily Living *(Standalone measure)*
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Activities of Daily Living assessments for patients who have been in the Vulnerable Patient

Network (Home Visits) program for at least 6 months at the time of survey administration by at least 5% over DY2.

- DY5:
  - IT-10.2: Activities of Daily Living *(Standalone measure)*
    - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Activities of Daily Living assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 7% over DY2.

Rationale

Measurement of the activities of daily living is critical because they have been found to be significant predictors of paid home care , use of hospital services, living arrangements, use of physician, insurance coverage and mortality.[484] While ADLs are typically used with the elderly population, the complexity and nature of the high risk uninsured/Medicaid patients warrants this assessment as well. Monitoring the progress or decline of factors such as bathing, feeding, continence, transferring, toileting and dressing are immediate predictors of any issues or barriers that patients may be experiencing.[485] We may need to consider using the Lawton IADL scale for this population as it involves more complex activities such as: shopping, laundry, responsibility for own medications, etc.[486] We plan on conducting the ADL assessment every 6 months and patients that have been in the program for 6 months. The improvement will be measured from the time that patients enroll in the program to survey conduction.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

[484] Measuring ADLs Across National Surveys: http://aspe.hhs.gov/daltcp/reports/meacmpes.htm

[485] Katz, Sidney. 1983. "Assessing Self-Maintenance: Activities of Daily Living, Mobility, and Instrumental Activities of Daily Living." *Journal of the American Geriatrics Association* 31:721-727.

[486] Lawton, M. Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living. *The Gerontologist* 9:179-186.

121776204.2.4-Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)

121776204.3.17	*3.IT-10.2*	*Activities of Daily Living*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.2.4– Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)*		
Starting Point/Baseline:	***Baseline:*** *Baseline will be established in DY2. We do not currently track ADL assessments and improvements.* ***Target Population:*** *High risk, vulnerable patients who are unable to access care in an ambulatory care setting. The top 5% of high risk uninsured and Medicaid patients from the 872,000 uninsured in Dallas County.*		
Year 2 (10/1/2012 – 9/30/2013)	**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-1.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports. Documentation of ADL assessment tool chosen Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $7,368 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $7,368	**Outcome Improvement Target 1** [IT-10.2]: Quality of Life (Standalone) Improvement Target: > 3% improvement in mean ADL scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment: $17,080	**Outcome Improvement Target** [IT-10.2]: Quality of Life (Standalone) Improvement Target: > 5% improvement in mean ADL scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $27,408	**Outcome Improvement Target 3** [IT-10.2]: Quality of Life (Standalone) Improvement Target: > 7% improvement in mean ADL scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 65,540
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 14,735	Year 3 Estimated Outcome Amount: $ $17,080	Year 4 Estimated Outcome Amount: $27,408	Year 5 Estimated Outcome Amount: $ 65,540
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 124,763			

Title of Outcome Measure (Improvement Target): IT-1.2 Annual monitoring for patients on persistent medication– angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (*Non- standalone measure*)

Unique RHP Outcome Identification Number: 121776204.3.18

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description:
IT-1.2: Annual monitoring for patients on persistent medications angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (*Non- standalone measure*)
Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
Percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Since we do not have a baseline for patients receiving a serum potassium, serum creatinine or blood urea nitrogen test during the measurement year, we are proposing the following tiers of improvement:

- If 25-50% of patients on an ACE/ARB inhibitor are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 5% in DY3, 10% in DY4 and 15% in DY5 (all over DY2 baseline)
- If 50-75% of patients on an ACE/ARB inhibitor are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 5% in DY3, 7% in DY4 and 9% in DY5 (all over DY2 baseline)
- If 75-90% patients on an ACE/ARB inhibitor are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 2% in DY3, 4% in DY4 and 6% in DY5 (all over DY2 baseline)
- If 90% or more patients on an ACE/ARB inhibitor are receiving a serum potassium/creatinine or BUN test within one year then we will not pursue this outcome improvement and will defer to using only IT-1.19 Antidepressant Medication Management (Standalone)

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
        - We will establish our baseline rate. Based on clinician input, we believe about 33% of patients in Baylor Clinics are on an ACE/ARB

inhibitor. We do not have any data on how many of those patients received a serum potassium/creatinine or BUN test in the past year.

Outcome Improvement Targets for each year

- DY3:
  - IT-1.2: Annual monitoring for patients on ACE or ARBs (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 2% or 5% depending on baseline established in DY2
- DY4:
  - IT-1.2: Annual monitoring for patients on ACE or ARBs (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 4%, 5% or 10% depending on baseline in DY2
- DY5:
  - IT-1.2: Annual monitoring for patients on ACE or ARBs (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 6%, 9% or 15% depending on the baseline in DY2

Rationale

Approximately 33% of Baylor Clinic patients are on an ACE/ARB medication regimen. Enforcing annual monitoring will improve quality and reconcile the patient's medication to ensure it is still appropriate. In a recent study in the New England Journal of Medicine, compliance to anti-hypertensives was 41%, beta blockers was 49% and statins were 55% after a patient suffered from an AMI.[487] We believe through consistent, proactive management and encouraging patient accountability for taking medications, these rates should increase.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or

[487] Choudhry, NK, Avorn, J, et. al. Full coverage for preventive medications after myocardial infarction. N Engl J Med 2011; 365:2088-2097

diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.2.5- Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

121776204.3.18	*3.IT-1.2*	*Annual monitoring for patients on persistent medication– angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.2.5– Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*		
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 33% of Baylor Clinic patients take an ACE or ARB inhibitor. We do not know the rate of monitoring for serum potassium/creatinine or BUN.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on an ACE/ARB inhibitor*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $3267 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $3267	**Outcome Improvement Target 1** [IT-1.2]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) ACE inhibitors or ARBs (*Non-standalone measure*) Improvement Target: > 2% of patient 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $7573	**Outcome Improvement Target 2** [IT-1.2]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) ACE inhibitors or ARBs (*Non- standalone measure*) Improvement Target: > 4% of patient 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $12,152	**Outcome Improvement Target 3** [IT-1.2]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) ACE inhibitors or ARBs (*Non- standalone measure*) Improvement Target: > 6% of patient 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $29,060
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $6,534	Year 3 Estimated Outcome Amount: $7,573	Year 4 Estimated Outcome Amount: $12,152	Year 5 Estimated Outcome Amount: $29,060
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $55,319			

Title of Outcome Measure (Improvement Target): IT-1.4 Annual monitoring for patients on persistent medications diuretic *(Non- standalone measure)*
Unique RHP Outcome Identification Number: 121776204.3.19

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description:
IT-1.4: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non- standalone measure)*
Percentage of members 18 years of age and older who received at least 180 treatment days of a diuretic during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Since we do not have a baseline for patients receiving a serum potassium, serum creatinine or blood urea nitrogen test during the measurement year, we are proposing the following tiers of improvement:

- If 25-50% of patients on a diuretic are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 5% in DY3, 10% in DY4 and 15% in DY5 (all over DY2 baseline)
- If 50-75% of patients on a diuretic are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 5% in DY3, 7% in DY4 and 9% in DY5 (all over DY2 baseline)
- If 75-90% patients on a diuretic are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 2% in DY3, 4% in DY4 and 6% in DY5 (all over DY2 baseline)
- If 90% or more patients on a diuretic are receiving a serum potassium/creatinine or BUN test within one year then we will not pursue this outcome improvement and will defer to using only IT-1.19 Antidepressant Medication Management (Standalone)

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
        - We will establish our baseline rate. Based on clinician input, we believe about 33% of patients in Baylor Clinics are on a diuretic. We do not have any data on how many of those patients received a serum potassium/creatinine or BUN test in the past year.

Outcome Improvement Targets for each year

- DY3:
    - IT-1.4: Annual monitoring for patients a diuretic (Non-Standalone)
        - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 2% or 5% depending on baseline established in DY2
- DY4:
    - IT-1.4: Annual monitoring for patients a diuretic (Non-Standalone)
        - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 4%, 5% or 10% depending on baseline in DY2
- DY5:
    - IT-1.4: Annual monitoring for patients a diuretic (Non-Standalone)
        - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 6%, 9% or 15% depending on the baseline in DY2

Rationale

Approximately 33% of Baylor Clinic patients on a diuretic medication regimen. Enforcing annual monitoring will improve quality and reconcile the patient's medication to ensure it is still appropriate. A study that observed the correlation between a diuretic regimen and cardiovascular related hospitalizations found that patients who take the appropriate dose of diuretics at the appropriate time had a decrease risk of cardiovascular and heart failure related hospitalizations. A large component of the successful adherence was attributed to patient education and engagement in the medication regimen.[488]

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

[488] Chui, M. A., Deer, M., Bennett, S. J., Tu, W., Oury, S., Brater, D. C. and Murray, M. D. (2003), Association Between Adherence to Diuretic Therapy and Health Care Utilization in Patients with Heart Failure. Pharmacotherapy, 23: 326–332. doi: 10.1592/phco.23.3.326.32112

121776204.2.5- Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

121776204.3.19	*3.IT-1.4*	*Annual monitoring for patients on persistent medications diuretic (Non- standalone measure)*

Baylor Medical Center at Irving	*121776204*

Related Category 1 or 2 Projects:	*121776204.2.5***–** *Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 33% of Baylor Clinic patients take a diuretic. We do not know the rate of monitoring for serum potassium/creatinine or BUN.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on a diuretic*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $3267 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $3267	**Outcome Improvement Target 1** [IT-1.4]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non- standalone measure)* Improvement Target: > 2% of patient 18 years of age and older who received at least 180 treatment days of diuretics during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $7573	**Outcome Improvement Target 2** [IT-1.4]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non-standalone measure)* Improvement Target: > 4% of patient 18 years of age and older who received at least 180 treatment days of diuretics during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $12,152	**Outcome Improvement Target 3** [IT-1.4]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non-standalone measure)* Improvement Target: > 6% of patient 18 years of age and older who received at least 180 treatment days of diuretics during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $29,060
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $6,534	Year 3 Estimated Outcome Amount: $7,573	Year 4 Estimated Outcome Amount: $12,152	Year 5 Estimated Outcome Amount: $29,060

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $55,319

Title of Outcome Measure (Improvement Target): IT-1.5 Annual monitoring for patients on persistent medications-anticonvulsant *(Non- standalone measure)*
Unique RHP Outcome Identification Number: 121776204.3.20

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description:
IT-1.5: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non- standalone measure)*
Percentage of members 18 years of age and older who received at least 180 treatment days for an anticonvulsant during the measurement year and had at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year.

Since we do not have a baseline for patients receiving a serum concentration test during the measurement year, we are proposing the following tiers of improvement:

- If 25-50% of patients on an anticonvulsant are receiving a serum concentration test within one year then our improvements will be 5% in DY3, 10% in DY4 and 15% in DY5 (all over DY2 baseline)
- If 50-75% of patients on an anticonvulsant are receiving a serum concentration test within one year then our improvements will be 5% in DY3, 7% in DY4 and 9% in DY5 (all over DY2 baseline)
- If 75-90% of patients on an anticonvulsant are receiving a serum concentration test within one year then our improvements will be 2% in DY3, 4% in DY4 and 6% in DY5 (all over DY2 baseline)
- If 90% of patients on an anticonvulsant are receiving a serum concentration test within one year then we will not pursue this outcome improvement and will defer to using only IT-1.19 Antidepressant Medication Management (Standalone)

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
        - We will establish our baseline rate. Based on clinician input, we believe about 5% of patients in Baylor Clinics are on an anticonvulsant. We do not have any data on how many of those patients received a serum test in the past year.

Outcome Improvement Targets for each year

- DY3:

    - IT-1.5: Annual monitoring for patients an anticonvulsant (Non-Standalone)
        - Our goal is increase the % of patients that have had a serum concentration test in the past year to 2% or 5% depending on baseline established in DY2
- DY4:
    - IT-1.5: Annual monitoring for patients an anticonvulsant (Non-Standalone)
        - Our goal is increase the % of patients that have had a serum concentration test in the past year to 4%, 5% or 10% depending on baseline in DY2
- DY5:
    - IT-1.5: Annual monitoring for patients an anticonvulsant (Non-Standalone)
        - Our goal is increase the % of patients that have had a serum concentration test in the past year to 6%, 9% or 15% depending on the baseline in DY2

Rationale

Only about 5% of Baylor Clinic patients are on an anticonvulsant medication regimen. This may be because there are no formal behavioral health programs in the Baylor Clinic, it is possible that identification of BH issues is low and utilization of anticonvulsants would increase with an increased emphasis on identifying BH issues. A study in Psychiatric Services found that 50% of patients that were given anticonvulsant prescriptions to treat bipolar disorder were non-adherent.[489] This issue can be resolved by explaining the risks v. benefits for taking an anticonvulsant.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

[489] Sajattovic, M, et. al. Treatment adherence with lithium and anticonvulsant medications among patients with bipolar disorder. *Psychiatric Services*. 58(6):855-63. 2007.

Related Category 1 and/or 2 projects

121776204.2.5- Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

121776204.3.20	*3.IT-1.5*	*Annual monitoring for patients on persistent medications-anticonvulsant (Non- standalone measure)*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.2.5***–** *Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*		
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 5% of Baylor Clinic patients take an anticonvulsant. We do not know the rate of monitoring for serum concentration testing.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on an anticonvulsant.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $3267 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $3267	**Outcome Improvement Target 1** [IT-1.5]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non- standalone measure)* Improvement Target: > 2% of patients 18 years of age and older who received at least 180 treatment days of anticonvulsants during the measurement year and had at least one serum concentration test in the measurement year. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $7573	**Outcome Improvement Target 2** [IT-1.5]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non-standalone measure)* Improvement Target: > 4% of patients 18 years of age and older who received at least 180 treatment days of anticonvulsants during the measurement year and had at least one serum concentration test in the measurement year. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $12,152	**Outcome Improvement Target 3** [[IT-1.5]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non-standalone measure)* Improvement Target: > 6% of patient s18 years of age and older who received at least 180 treatment days of anticonvulsants during the measurement year and had at least one serum concentration test in the measurement year. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $29,060
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $6,534	Year 3 Estimated Outcome Amount: $7,573	Year 4 Estimated Outcome Amount: $12,152	Year 5 Estimated Outcome Amount: $29,060
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $55,319			

Title of Outcome Measure (Improvement Target): IT-1.19 Antidepressant Medication Management *(Standalone measure)*
Unique RHP Outcome Identification Number: 121776204.3.21

Performing Provider Name/TPI: Baylor Medical Center at Irving/121776204

Outcome Description:
IT-1.19: Antidepressant Medication Management - NQF 0105237 *(Standalone measure)*

Numerator:

A) Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

B) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period.Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).

Denominator: Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year.
***Note** because this project will occur in an ambulatory setting, we will need to modify the denominator to more accurately measure the impact of this outcome. Instead of members discharged from an acute inpatient setting with a mental health diagnosis (as many of these patients may not come to a Baylor Clinic), we propose changing the denominator to all patients at a Baylor Clinic on the Baylor Medical Center at Irving campus with an identified mental health issue and on a psychiatric medication.

We do not have an established baseline of tracking patients who received Acute Phase/Continuation phase treatment with antidepressants. Based on the baseline analysis in DY2, we may have to reevaluate or modify this outcome.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline rates
    - We will establish our baseline rate. Based on clinician input, we believe about 20% of patients in Baylor Clinics are on an antidepressant. We do not have any data on how many of those patients received acute/continuous phase treatment.

Outcome Improvement Targets for each year

- DY3:
  - IT-1.19: Antidepressant Medication Management (Standalone)
    - Our goal is increase the % of patients that have are engaged in Effective Acute Phase Treatment by 5%
    - Our goal is to increase the % of patients that have engaged in Effective Continuous Phase Treatment by 3%
- DY4:
  - IT-1.19: Antidepressant Medication Management (Standalone)
    - Our goal is increase the % of patients that have are engaged in Effective Acute Phase Treatment by 10%
    - Our goal is to increase the % of patients that have engaged in Effective Continuous Phase Treatment by 5%
- DY5:
  - IT-1.19: Antidepressant Medication Management (Standalone)
    - Our goal is increase the % of patients that have are engaged in Effective Acute Phase Treatment by 15%
    - Our goal is to increase the % of patients that have engaged in Effective Continuous Phase Treatment by 7%

Rationale

Approximately 20% of Baylor Clinic patients on an antidepressant medication regimen. According to the Community Health Needs Assessment, behavioral health is a major issue in the region. The top 10 utilizers in the region had BH related issues.[490] While antidepressants are not the solution to this problem, managing depression can have other positive ancillary effects on clinical adherence and avoidance of BH exacerbations. This outcome enforces both short and long term adherence to this drug in order to avoid adverse events for patients. An article in the Journal of Clinical Psychiatry, evidence was found "…to support collaborative care interventions in a primary care setting demonstrated significant improvements in antidepressant drug

[490] RHP 9 Community Health Needs Assessment

adherence during the acute and continuous phase of treatment and were associated with clinical benefit, especially in patients suffering from major depression and were prescribed adequate dosages of antidepressant medication.[491]" Our project supports this methodology.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

121776204.2.5- Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

[491] Vergouwen, AC, et. al. Improving adherence to antidepressants: a systematic review of interventions. *J Clin Psychiatry.* 64(12):1415-20. 2003.

121776204.3.21	*3.IT-1.19*	*Antidepressant Medication Management (Non- standalone measure)*	
Baylor Medical Center at Irving			*121776204*
Related Category 1 or 2 Projects:	*121776204.2.5***–** *Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*		
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 20% of Baylor Clinic patients take an anticonvulsant. We do not know the rate of monitoring for serum concentration testing.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on an antidepressant.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $3267 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $3267	**Outcome Improvement Target 1** [IT-1.19]: Antidepressant Medication Management - NQF 0105237 *(Standalone measure)* Improvement Target: • Increase the % of patients that have are engaged in Effective Acute Phase Treatment by 5% • Increase the % of patients that have engaged in Effective Continuous Phase Treatment by 3% Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment: $7574	**Outcome Improvement Target 2** [IT-1.19]: Antidepressant Medication Management - NQF 0105237 *(Standalone measure)* Improvement Target: • Increase the % of patients that have are engaged in Effective Acute Phase Treatment by 10% • Increase the % of patients that have engaged in Effective Continuous Phase Treatment by 5% Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $12,153	**Outcome Improvement Target 3** [IT-1.19]: Antidepressant Medication Management - NQF 0105237 *(Standalone measure)* Improvement Target: • Increase the % of patients that have are engaged in Effective Acute Phase Treatment by 15% • Increase the % of patients that have engaged in Effective Continuous Phase Treatment by 7% Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $29,060
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $6,534	Year 3 Estimated Outcome Amount: $7,574	Year 4 Estimated Outcome Amount: $12,153	Year 5 Estimated Outcome Amount: $29,060
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $55,321			

Title of Outcome Measure (Improvement Target): IT-1.7 Controlling High Blood Pressure (NCQA-HEDIS, 2012, NQF 0018) **(Standalone)**

Unique RHP Outcome Identification Number: 139485012.3.1

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Description:

IT-1.7: Controlling high blood pressure *(Standalone measure)*

- Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year
- Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension

As one of our primary care metrics we chose blood pressure. As high blood pressure is a prerequisite to many other chronic illnesses and serious medical conditions, getting BP under control with proper PCP supervision, medications and regular visits can help patients' quality of life and overall health.

By the end of the waiver, our goal is to have > 59.0% (or 6.8% total improvement over established baseline) of patients who are Baylor Clinic at Baylor University Medical Center have good blood pressure control (< 140/80 mmHg). This is a projected 6.8% improvement over baseline. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic.

Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
        - We will confirm and establish our baseline. Baylor currently tracks BP control and uses a threshold of < 130/80 mmHg for patients that have hypertension. Based on our current data, 52.2% of patients with hypertension have controlled BP (130/80 mmHg)

Outcome Improvement Targets for each year

- DY3:
  - [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)
    - Our goal is increase the % of patients that have BP control (< 140/80 mmHg) to 54.6% (or 2.4% improvement over baseline established in DY2)
- DY4:
  - [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)
    - Our goal is increase the % of patients that have BP control (< 140/80 mmHg) to 56.9% (or 4.7% improvement over baseline established in DY2)
- DY5:
  - [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone)
    - Our goal is increase the % of patients that have BP control (< 140/80 mmHg) to 59.0% or 6.8% improvement over baseline established in DY2)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Controlling high blood pressure is essential in avoiding heart attacks, stroke, heart failure and a multitude of other diseases and complications. Through medication management, proper primary care attention and education, patients can achieve better blood pressure control in the outpatient setting. In Region 9, Hypertension was identified as one of the top 5 most prevalent diseases in the area for ED visits.[492] A recent article in the New York Times suggested that hypertensive complications can be especially deadly in the African American population, who make up 22.5% of the RHP 9 population[493]. Blood pressure is a standard metric that all Baylor Clinics monitor and regulate. Patients who are uncontrolled will receive the attention they need to get their hypertension under control. Patients will receive medication management, lifestyle

[492] RHP 9 Community Health Needs Assessment
[493] http://health.nytimes.com/health/guides/disease/hypertension/complications.html

management techniques and education about their illness in this clinic PCMH setting. Our metrics and milestones are designed to increase improvement in BP control for the target population.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

139485012.3.1	*3.IT-1.7*	*Controlling high blood pressure*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.1.1- Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor University Medical Center had 52.2% of patients with controlled BP (130/80 mmHg)* ***Target Population:*** *Underserved/uninsured patients in Dallas without a PCP/PCMH with uncontrolled BP (>140/80 mmHg)*		
Year 2 (10/1/2012 – 9/30/2013)	**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-1.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 41,711 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount): $* 41,711	**Outcome Improvement Target 1** [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone) Improvement Target: > 54.6% (or 2.4% over DY2 baseline) of new patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $96,697	**Outcome Improvement Target 2** [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone) Improvement Target: > 56.9% (or 4.7% over DY2 baseline) of new patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $155,164	**Outcome Improvement Target 3** [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone) Improvement Target: > 59.0% (or 6.8% over DY2 baseline) of new patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $371,046
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $83,422	Year 3 Estimated Outcome Amount: $96,697	Year 4 Estimated Outcome Amount: $155,164	Year 5 Estimated Outcome Amount: $371,046
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $706,329			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores (**Standalone measure)**

1) Patients are getting timely care, appointments and information (Standalone measure) : Measurement of Satisfaction Related to Clinic Wait Times

Unique RHP Outcome Identification Number: 139485012.3.2

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Measure Description

IT-6.1: 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. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(1) are getting timely care, appointments, and information; ***(Standalone measure)***
(2) how well their doctors communicate; ***(Standalone measure)***
(3) patient's rating of doctor access to specialist; ***(Standalone measure)***
(4) patient's involvement in shared decision making, and ***(Standalone measure)***
(5) patient's overall health status/functional status. ***(Standalone measure)***

Patient satisfaction is an important part of overall treatment and encourages participation and compliance of patients' in their own care. For this metric we will be measuring is to improve the satisfaction scores in regards to clinic wait times. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic.

By the end of the waiver, our goal is to have the Baylor Clinic at Baylor University Medical Center obtain a patient satisfaction score of 86.1% (or at least a total of 2.3% improvement over established baseline) on the survey question related to wait time to appointment satisfaction. This falls under metric (1)- patients are getting timely care, appointments and information of 3.6.1, option (1). Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Although the Baylor Clinic at Baylor University Medical Center is at a 83rd percentile score of patients satisfaction related to this particular metric, we believe there is still opportunity to improve and that with any incremental gain in patient satisfaction equates to better compliance and outcomes for our patients. The baseline percentile score of 83.8% is equivalent to a 52 percentile score nationally, which also presents an opportunity to improve for this Baylor Clinic. By maintaining high standards and enforcing metrics around satisfaction for our staff, we will continue to pursue high patient satisfaction scores in our Baylor Clinics.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will confirm and establish our baseline. Currently, the Baylor Clinic at Baylor University Medical Center is at 83.8% satisfaction with clinic wait times

Outcome Improvement Targets for each year

- DY3:
    - IT-6.1: Percent improvement of patient satisfaction scores
        - Our goal is increase the % of patient satisfaction related to wait times to 84.6% (or 0.8% improvement over DY2 baseline)
- DY4:
    - IT-6.1: Percent improvement of patient satisfaction scores
        - Our goal is increase the % of patient satisfaction related to wait times to 85.4% (or 1.6% improvement over DY2 baseline)
- DY5:
    - IT-6.1: Percent improvement of patient satisfaction scores
        - Our goal is increase the % of patient satisfaction related to wait times to 86.1% (or 2.3% improvement over DY2 baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Data from Press Ganey Associates in 2007 has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease[494]. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less physician/staff time, reducing length of visits and wait times for the overall practice. Baylor Clinics have historically had high performance in all measures related to

[494] Drain, M., & Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

patient satisfaction; however there is opportunity for improvement. This outcome has an impact on the region through increasing utilization of outpatient based primary care. If patients are satisfied, they will continue to come to their appointments, stay healthier and stay out of the ED. We anticipate that we will be able to raise patient satisfaction in the domains mentioned below through the Baylor Clinic PCMH model.

1) Patients are getting timely care, appointments and information (Standalone measure): We will measure this particular metric through monitoring and improving the survey question around improving clinic wait times for patients

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

139485012.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.1.1*- Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor University Medical Center had a satisfaction rate related to clinic wait times of 83.8%* ***Target Population:*** *Underserved/uninsured patients in a Baylor Clinic PCMH in Dallas*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 31,283	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 84.6% (or 0.8% over DY2) (new patient satisfaction rate with clinic wait times) will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 36,261	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 85.4% (or 1.6% over DY2) new patient satisfaction with clinic wait times will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 58,187	**Outcome Improvement Target 3** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 86.1% (or 2.3% over DY2) new patient satisfaction with clinic wait times will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 139,142
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 31,283	Year 3 Estimated Outcome Amount: $ 36,261	Year 4 Estimated Outcome Amount: $ 58,187	Year 5 Estimated Outcome Amount: $139,142
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 264,873			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores (**Standalone measure)**

2) Patients are getting timely care, appointments and information (Standalone measure): Measurement of Satisfaction Related to Response Time to Patient Phone Calls

Unique RHP Outcome Identification Number: 139485012.3.3

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Measure Description

IT-6.1: 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. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(1) are getting timely care, appointments, and information; ***(Standalone measure)***
(2) how well their doctors communicate; ***(Standalone measure)***
(3) patient's rating of doctor access to specialist; ***(Standalone measure)***
(4) patient's involvement in shared decision making, and ***(Standalone measure)***
(5) patient's overall health status/functional status. ***(Standalone measure)***

Patient satisfaction is an important part of overall treatment and encourages participation and compliance of patients' in their own care. For this metric we will be measuring improvement in the responsiveness to patient phone calls in a timely manner.

By the end of the waiver, our goal is to have the Baylor Clinic at Baylor University Medical Center obtain a patient satisfaction score of 87.3% (or a minimum of 2.1% total improvement over established baseline) on the survey question related to patient phone calls being returned in a timely fashion. This falls under metric (2) Patients are getting timely care, appointments and information of 3.6.1, option (2). Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic

Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- We will confirm and establish our baseline. Currently, the Baylor Clinic at Baylor University Medical Center is at 85.2% satisfaction with patients receiving a response to their phone calls in a timely manner

Outcome Improvement Targets for each year

- DY3:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - Our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 85.9% (or 0.7% improvement over DY2 baseline)
- DY4:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - Our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 86.6% (or 1.4% improvement over DY2 baseline)
- DY5:
  - IT-6.1: Percent improvement of patient satisfaction scores
    - Our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 87.3% (or 2.1% improvement over DY2 baseline)

Although the Baylor Clinic at Baylor University Medical Center is at a 85th percentile score of patients satisfaction related to this particular metric, we believe there is still opportunity to improve and that with any incremental gain in patient satisfaction equates to better compliance and outcomes for our patients. The baseline percentile score of 85.2% is equivalent to a 62 percentile score nationally, which also presents an opportunity to improve for this Baylor Clinic. By maintaining high standards and enforcing metrics around satisfaction for our staff, we will continue to pursue high patient satisfaction scores in our Baylor Clinics.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider.

Data from Press Ganey Associates in 2007 has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease[495]. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less physician/staff time, reducing length of visits and wait times for the overall practice. Baylor Clinics have historically had high performance in all measures related to patient satisfaction; however there is opportunity for improvement. This outcome has an impact on the region through increasing utilization of outpatient based primary care. If patients are satisfied, they will continue to come to their appointments, stay healthier and stay out of the ED. We anticipate that we will be able to raise patient satisfaction in the domains mentioned below through the Baylor Clinic PCMH model.

2) Patients are getting timely care, appointments and information (Standalone measure): We will measure this particular metric through monitoring and improving the survey question around response times to patient phone calls

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

[495] Drain, M., & Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

139485012.3.3	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.1.1-Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor University Medical Center had a satisfaction rate related to clinic response to patient phone call of 85.2%* ***Target Population:*** *Underserved/uninsured PCMH patients of the Baylor Clinic in the Dallas area*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 31,283	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 85.9% (or 0.7% over DY2) new patient satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 36,261	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 86.6% (or 1.4% over DY2) new patient satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $58,187	**Outcome Improvement Target 3** [IT-6.1]: Percent improvement of patient satisfaction scores (Standalone) Improvement Target: > 87.3% (or 2.1% over DY2) new patient satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 3 Estimated Incentive Payment*:* $139,142
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $31,283	Year 3 Estimated Outcome Amount: $ 36,261	Year 4 Estimated Outcome Amount: $58,187	Year 5 Estimated Outcome Amount: $139,142
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 264,873			

Title of Outcome Measure (Improvement Target): IT-12.1 Breast Cancer Screening (Non-Standalone)

Unique RHP Outcome Identification Number: 139485012.3.4

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Measure Description

IT-12.1: Breast Cancer Screening (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

By the end of the waiver, our goal is to have > 64.6% (or a minimum of 5.9% total improvement over established baseline) of women ages 40-69 who are patients of the Baylor Clinic at Baylor University Medical Center to have a breast cancer screening. This is a 5.9% improvement over the waiver period. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic.

Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will confirm and establish our baseline. The Baylor Clinic at Baylor University Medical Center is at a 58.7% screening rate for women between 40-69

Outcome Improvement Targets for each year

- DY3:
    - IT-12.1: Breast Cancer Screening (HEDIS 2012) (Non-Standalone)
        - Our goal is increase the % of patients have had a breast cancer screen to at least 60.8% (or 2.1% improvement over DY2 baseline)
- DY4:
    - IT-12.1: Breast Cancer Screening (HEDIS 2012) (Non-Standalone)

        - Our goal is increase the % of patients have had a breast cancer screen to at least 62.7% (or 4.0% improvement over DY2 baseline)
        -
- DY5:
    - IT-12.1: Breast Cancer Screening (HEDIS 2012) (Non-Standalone)
        - Our goal is increase the % of patients have had a breast cancer screen to at least 64.6% (or 5.9% improvement over DY2)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

In Dallas County, 23.7/100,000 women die from breast cancer, with a higher rate of 37/100,000 for African American women.[496] There is room for improvement with this metric to screen more women and utilize early detection methods for breast cancer.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

[496] Healthy People North Texas: http://www.healthyntexas.org

139485012.3.4	*3.IT-12.1*	*Breast Cancer Screening*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.1.1-Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor University Medical Center had only 58.7% of women over the age of 40 receive a breast cancer screen* ***Target Population:*** *Underserved women in Dallas County that are over the age of 40*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $52,139	**Outcome Improvement Target 1** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone) Improvement Target: > 60.8% (or 2.1% over DY2 baseline) of new women over the age of 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $60,435	**Outcome Improvement Target 2** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone) Improvement Target: > 62.7% (or 4.0% over DY2 baseline) of new women over the age of 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 96,978	**Outcome Improvement Target 3** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Standalone) Improvement Target: > 64.6% (or 5.9% over DY2 baseline) of new women over the age of 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 231,903
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $52,139	Year 3 Estimated Outcome Amount: $60,435	Year 4 Estimated Outcome Amount: $ 96,978	Year 5 Estimated Outcome Amount: $ 231,903
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 441,455			

Title of Outcome Measure (Improvement Target): IT-12.5 Other USPSTF-endorsed screening outcome measures (Non-Standalone): Influenza Vaccination Rate

Unique RHP Outcome Identification Number: 139485012.3.5

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Description

IT-12.5: Other USPSTF-endorsed screening outcome measures

As part of primary care, the influenza vaccine is a simple, cost effective way for patients to protect themselves from the flue and other potential clinical exacerbations.

By the end of the waiver, our goal is to have > 59.3% (or a minimum of 6.8% total improvement over established baseline) of Baylor Clinic patients over the age of 18 receive an influenza vaccination. This is an improvement of 6.8% over baseline. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic

Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will confirm and establish our baseline. The Baylor Clinic at Baylor University Medical Center is at a 52.5% rate for patients over the age of 18 that have received an influenza vaccine in the past 12 months

Outcome Improvement Targets for each year

- DY3:
    - IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone)
        - Our goal is increase the % of patients >18 years old that have had an influenza vaccination in the past 12 months to 54.9% (or 2.4% improvement over DY2 baseline)
- DY4:

- IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone)
    - Our goal is increase the % of patients >18 years old that have had an influenza vaccination in the past 12 months to 57.1% (or 4.6% improvement over DY2 baseline)

- DY5:
    - IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone)
        - Our goal is increase the % of patients >18 years old that have had an influenza vaccination in the past 12 months to 59.3% (or 6.8% improvement over DY2 baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

In Dallas County, only 65% of individuals over the age of 18 received an influenza vaccination in the past 12 months.[497] The rate of influenza vaccinations in the Region is quite low and there is an opportunity to increase the number in the target population that receive this basic vaccination in order to prevent exacerbations of health issues, reduce the prevalence of influenza and prevent ED visits related to influenza that can otherwise be handled in an outpatient setting.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or

[497] Healthy People North Texas: http://www.healthyntexas.org

diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.1.1 Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion

139485012.3.5	*IT-12.5*	*Other USPSTF-endorsed screening outcome measures (Influenza Vaccination)*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.1.1- Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor University Medical Center had 52.5% of patients over the age of 18 receive an influenza vaccination* ***Target Population:*** *Underserved/uninsured patients 18 years and older in Dallas County*		
Year 2 (10/1/2012 – 9/30/2013)	**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-1.1] Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete planning processes for primary care expansion Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 52,139	**Outcome Improvement Target 1** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone) Improvement Target: > 54.9% (or 2.4% over DY2 baseline) of new patients over the age of 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 60,435	**Outcome Improvement Target 2** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone) Improvement Target: > 57.1 (or 4.6% over DY2 baseline) of new patients over the age of 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 96,978	**Outcome Improvement Target 3** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Standalone) Improvement Target: > 59.3% (or 6.8% over DY2 baseline) of new patients over the age of 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 231,903
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $52,139	Year 3 Estimated Outcome Amount: $60,435	Year 4 Estimated Outcome Amount: $ 96,978	Year 5 Estimated Outcome Amount: $ 231,903
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 441,455			

Title of Outcome Measure (Improvement Target): IT-11.1 Improvement in Clinical Indicator in identified disparity group: Improvement in Asthma Percent of Opportunities Achieved

Unique RHP Outcome Identification Number: 139485012.3.6

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Measure Description

The disparity group for this metric is the underserved/uninsured population in Dallas County that has uncontrolled Asthma.

IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider *(Standalone measure)*

- Numerator: Number of asthma opportunities completed/fulfilled
- Denominator: Asthma appropriate opportunities x number of asthma patients

By the end of the waiver, our goal is to have achieved a 40.0% (or 10% improvement over baseline) percent of opportunities achieved for the Baylor Health Care System Asthma Percent of Opportunity Achieved (POA). This is an aggressive 10% improvement target over baseline. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

At Baylor Health Care System, we have a standard Asthma POA which consists of: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. We measure this yearly for our Asthma patients and calculate POA by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population.

POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in asthma management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their asthma patients than in the prior reporting period.

For an illustrative example: For Asthma- there are 4 potential opportunities (i.e. metrics) per patient (1) documentation of Action/Mgmt Plan, 2) Severity Assessment, 3) Controller Therapy for those who are eligible, and 4) Spirometry within last two years). The denominator would be # of patients x 4. So, for example, if there are 10 patients x 4 opportunities each = 40

opportunities to be achieved. If, in the course of the year, only 30 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 30/40=75%. To achieve a 10% improvement in POA, we would have to have completed at least 34/40 opportunities to get at 85% achievement.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that 30% POA was achieved for Asthma patients

Outcome Improvement Targets for each year

- DY3:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Asthma Percent of Opportunities Achieved)
        - Our goal is to increase the POA % for Asthma patients to 33.5% (or 3.5% improvement over baseline)
- DY4:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Asthma Percent of Opportunities Achieved)
        - Our goal is to increase the POA % for Asthma patients to 36.8% (or 6.8% improvement over baseline)
- DY5:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Asthma Percent of Opportunities Achieved)
        - Our goal is to increase the POA % for Asthma patients to 40.0% (or 10% improvement over baseline)

In order to meet these improvements, primary care and specialists in the community will have to work together to meet these goals. We feel that Pulmonologists should handle more complex cases but also use this opportunity to help educate the underserved population (especially Hispanics and African Americans) about the importance of screenings/prevention.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Metrics selected were based on historical data from similar programs with specialty care providers that showed material improvement in a 2-3 year time period.

We plan on measuring the improvement in Asthma for Baylor Clinic patients. At Baylor Health Care System, we have a standard Asthma Percent of Opportunities Achieved which consists of:

documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. We feel that this measure is a comprehensive way to measure the patients with Asthma in the Baylor Clinic and manage their condition holistically.

Asthma affects about 19.6% of the Dallas County population and had approximately 1158 cases of hospitalization in 2010.[498] According to the Office of Minority Health, African Americans were 30% more likely to have Asthma than non-Hispanic whites and were three times more likely to die from an Asthma related issue than non-Hispanic whites. Hispanics are 30% more likely to visit the hospital for Asthma than non-Hispanic whites.[499]

A study by Meng, Leung, et. al found that patients with Asthma that saw a specialist had higher rates of compliance because specialists were more likely to identify the disease and follow national guidelines and protocols to treat these patients leading to better quality outcomes and long(er) term control[500]. Making the pulmonologist a part of our Asthma patients' care team will help to avoid exacerbations, prevent complications and reduce hospitalizations.

Many of the underserved patients in the region require specialty care related to chronic diseases. Lack of timely access to needed care often results in clinical exacerbations and worsening of their health conditions. This can be avoided or lessened through improved access. A study conducted in 2010 by Bellinger, et al. confirmed that minority and underserved populations not only receive less care but access to care is mitigated by physician referral, geographic location and insurance type.[501]

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

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[498] Healthy People North Texas: http:///www.healthyntexas.org

[499] Office of Minority Health: http://www.minorityhealth.hhs.gov

[500] Meng YY, Leung KM, Berkbigler D, Halbert RJ. Compliance with US asthma management guidelines and specialty care: a regional variation or national concern? J Eval Clin Pract. 1999 May;5(2):213-21.

[501] Bellinger, JD, Hassan, RM, et.al. Specialty care use in US patients with chronic diseases. Int J. Envion. Res Public Health 2010, 7, 975-990.

Related Category 1 and/or 2 projects

139485012.1.2- Improve Access to Specialty Care-Expand Specialty Care Services

139485012.3.6	*3.IT-11.1*	*Improvement in Clinical Indicator in identified disparity group-Asthma management in underserved/uninsured population*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.1.2- Improve Access to Specialty Care-Expand Specialty Care Services*		
Starting Point/Baseline:	***Definition of Metric:*** *Percent of Opportunities Achieved for Asthma patients = Number of opportunities (metrics) fulfilled divided by the number of opportunities appropriate per patient x number of patients* ***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor University Medical Center Medical Center had achieved only 30% of Asthma POA for their patients* ***Target Population:*** *Underserved/uninsured patients in Dallas County with uncontrolled Asthma*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports/agreements with specialists Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $68,427	**Outcome Improvement Target 1** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 33.5% (or 3.5% improvement over baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 118,974	**Outcome Improvement Target 2** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 36.8% (or 6.8% improvement over baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $190,912	**Outcome Improvement Target 3** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 40.0% (or 10% improvement over baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $465,528
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $68,427	Year 3 Estimated Outcome Amount: $118,974	Year 4 Estimated Outcome Amount: $ 190,912	Year 5 Estimated Outcome Amount: $465,528
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 834,841			

Title of Outcome Measure (Improvement Target): IT-12.2 Cervical Cancer Screening (HEDIS 2012) (Non-Standalone Measure)

Unique RHP Outcome Identification Number: 139485012.3.7

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Measure Description

IT-12.2: Cervical Cancer Screening (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.

As part of preventive care and screenings, cervical cancer screening is a standard practice that PCP/PCMHs provide for their patients. Education and regular exams can be the difference between early detection and death. By the end of the waiver, our goal is to have > 73.3% (or 4.4% improvement over baseline) of patients who are Baylor Clinic at Baylor University Medical Center be screened for Cervical Cancer. This is a 4.4% improvement over baseline. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that 68.9% of patients at the Baylor Clinic at Baylor University Medical Center have had a Cervical Cancer screening

Outcome Improvement Targets for each year

- DY3:
  - IT-12.2: Cervical Cancer Screening
    - Our goal is increase the % of patients that have received a Cervical Cancer screening to at least 70.5% (or 1.6% improvement over baseline)
- DY4:
  - IT-12.2: Cervical Cancer Screening

        - Our goal is increase the % of patients that have received a Cervical Cancer screening to at least 71.9% (or 3% improvement over baseline)
- DY5:
    - IT-12.2: Cervical Cancer Screening
        - Our goal is increase the % of patients that have received a Cervical Cancer screening to at least 73.3% (or 4.4% improvement over baseline)

In order to meet these improvements, primary care and specialists in the community will have to work together to meet these goals. We feel that OB/GYNs should handle more complex cases but also use this opportunity to help educate underserved women about the importance of screenings and prevention.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Metrics selected were based on historical data from similar programs with specialty care providers that showed material improvement in a 2-3 year time period. In Dallas County approximately the incidence rate of cervical cancer is 9.7 per 100,000.[502] According to the National Cancer Institute, African American women are more likely to be diagnosed with cervical cancer and Hispanic women have the highest cervical cancer incidence rate amongst all women[503]. There is opportunity to increase the screenings in the minority population through engaging OB/GYNs to provide screenings and education for this population. Additionally, these specialists can provide the advanced screenings and education that would not be available in a PCP/PCMH setting.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome ,involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

[502] Healthy People North Texas: http://www.healthyntexas.org
[503] National Cancer Institute: http://www.cancer.gov

Related Category 1 and/or 2 projects

139485012.1.2- Improve Access to Specialty Care-Expand Specialty Care Service

139485012.3.7	*3.IT-12.2*	*Cervical Cancer Screening*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.1.2*- Improve Access to Specialty Care-Expand Specialty Care Services		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor University Medical Center had a screening rate of 68.9%* ***Target Population:*** *Underserved/uninsured women between the ages of 21-64 in Dallas*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports/agreements with specialists Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 68,427	**Outcome Improvement Target 1** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 70.5% (or 1.6% improvement over baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 59,487	**Outcome Improvement Target 2** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 71.9% (or 3% improvement over baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 95,456	**Outcome Improvement Target 3** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 73.3% (or 4.4% improvement over baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 228,264
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 68,427	Year 3 Estimated Outcome Amount: $ 59,487	Year 4 Estimated Outcome Amount: $ 95,456	Year 5 Estimated Outcome Amount: $ 228,264
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 451,634			

Title of Outcome Measure (Improvement Target): IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-Standalone Measure)

Unique RHP Outcome Identification Number: 139485012.3.8

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Measure Description

IT-12.3 Colorectal Cancer Screening (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.

By the end of the waiver, our goal is to have > 56.3% (or 7.3% improvement over baseline) of patients who are Baylor Clinic patients at Baylor University Medical Center be screened for Colorectal Cancer. This is an improvement of 7.3% over baseline. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that only 49.0% of patients at the Baylor Clinic at Baylor University Medical Center had a Colorectal Cancer Screening

Outcome Improvement Targets for each year

- DY3:
  - IT-12.3 Colorectal Cancer Screening
    - Our goal is increase the % of patients that have received a Colorectal Cancer screening to at least 51.6% (or 2.6% improvement over baseline)
- DY4:

- IT-12.3 Colorectal Cancer Screening
  - Our goal is increase the % of patients that have received a Colorectal Cancer screening to at least 54.0% (or 5.0% improvement over baseline)

- DY5:
  - IT-12.3 Colorectal Cancer Screening
    - Our goal is increase the % of patients that have received a Colorectal Cancer screening to at least 56.3% (or 7.3% improvement over baseline)

In order to meet these improvements, primary care and specialists in the community will have to work together to meet these goals. We feel that Gastroenterologists should handle more complex cases but also use this opportunity to help educate underserved adults about the importance of screenings and prevention. The Baylor Clinic is currently only at a 49% completion rate and will need the help of their specialist partners to meet these goals.

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Metrics selected were based on historical data from similar programs with specialty care providers that showed material improvement in a 2-3 year time period.

In Dallas County less than 60% of individuals 50 and over have had a sigmoidoscopy or colonoscopy examination. The colorectal cancer incidence rate is 43.3 cases per 100,000 people. 60% of deaths due to colorectal cancer can be avoided.[504] There is a definite need for these services in Dallas County and the Baylor Clinic plans to provide these screenings to a greater number of people. According to the Centers for Disease Control and Prevention, Hispanics and African Americans are less likely to get screened for colorectal cancer and it is often found in the latter stages of the disease as compared to their Caucasian counterparts.[505] There is an opportunity to increase the colorectal cancer screening rates by engaging specialists in the Dallas County area to provide these basic and advanced screenings along with education that is focused on this particular topic.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome

[504] Healthy People North Texas: http://www.healthyntexas.org
[505] Centers for Disease Control and Prevention: http://www.cdc.gov

involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.1.2- Improve Access to Specialty Care-Expand Specialty Care Services

139485012.3.8	*3.IT-12.3*	*Colorectal Cancer Screening*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.1.2*- Improve Access to Specialty Care-Expand Specialty Care Services		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor University Medical Center had a screening rate of 49.0%* ***Target Population:*** *Underserved/uninsured adults between the ages of 50-75 in Dallas County.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports/agreements with specialists Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 68,427	**Outcome Improvement Target 1** [IT-12.2]: Colorectal Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 51.6% (or 2.6% improvement over baseline) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 59,487	**Outcome Improvement Target 2** [IT-12.2]: Colorectal Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 54.0% (or 5.0% improvement over baseline) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 95,456	**Outcome Improvement Target 3** [IT-12.2]: Colorectal Cancer Screening (HEDIS) (Non-Standalone measure) Improvement Target: > 56.3% (or 7.3% improvement over baseline) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 228,264
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 68,427	Year 3 Estimated Outcome Amount: $ 59,487	Year 4 Estimated Outcome Amount: $ 95,456	Year 5 Estimated Outcome Amount: $ 228,264
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 451,634			

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure)

Unique RHP Outcome Identification Number: 139485012.3.9

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Measure Description

IT-1.10 Diabetes care: *HbA1c poor control (>9.0%) (Standalone measure)*

- Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

By the end of the waiver, our goal is to have < 14.9% (or minimum of 2.5% reduction over baseline) of patients 18-75 years old with diabetes (type 1 or type 2) out of glycemic control (HbA1c >9.0%). This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program. The additional qualifiers for this metric are the following: 1) a patient has been engaged in chronic care management for at least 6 months, 2) Two HbA1c measures will be taken per patient and the most recent HbA1c score will be used for reporting.

One of the outcome measures we have chosen for our chronic care management program is HbA1c performance, as determined by a reduction in poor control, defined as the percent of the population with HbA1c > 9.0%. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish Baseline Rates
        - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that at least 17.4% of patients at the Baylor Clinic at Baylor University Medical Center have an HbA1c > 9.0%

Outcome Improvement Targets for each year

- DY3:
    - IT-1.10: Diabetes Care: HbA1c poor control (> 9.0%)

        - Our goal is to reduce the HbA1c > 9.0% rate to ≤ 16.5% (or minimum of 0.9% reduction over baseline)
- DY4:
    - IT-1.10: Diabetes Care: HbA1c poor control (> 9.0%)
        - Our goal is to reduce the HbA1c > 9.0% rate to ≤ 15.7% (or minimum of 1.7% reduction over baseline)
- DY5:
    - IT-1.10: Diabetes Care: HbA1c poor control (> 9.0%)
        - Our end goal is to have the HbA1c > 9.0% rate be ≤ 14.9% (or minimum of 2.5% reduction over baseline)

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

In Dallas County, more than 11.4% of the population has a diagnosis of Diabetes.[506] Traditionally, the underserved population does not have access to the necessary medications and supplies to manage their diabetes thus many patients go undiagnosed or have poor glucose control. Lack of proper education coupled with a lack of primary care attention often leads to more severe complications and poor health outcomes for those with diabetes. This project would facilitate timely and appropriate care for those with diabetes and ensure that regular labs and point of care testing is completed to monitor results and make appropriate interventions.

Bodenheimer, et. al, found that patient self management of chronic disease conditions, such as diabetes, that was co-located in a primary care setting led to significant improvement in HbA1c control in patients.[507] A recent of edition of Managed Care found that patients with an HbA1c > 9 had on average almost $5000 worth of hospitalization costs, while those with an HbA1c of < 7 had about $2700 in hospitalization costs.[508] Focusing efforts on improving glycemic control should result in reduced co-morbid conditions and improved complication rates for these patients. We expect that at least 5-7% of patients that are seen regularly in a Baylor Clinic will have improved HbA1c levels.

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[506] RHP 9 Community Health Needs Assessment

[507] Bodenheimer, T., Lorig, K.., Holman, H., Grumbach, K. Patient Self-management of Chronic Disease in Primary Care *JAMA* (May 15, 2008).

[508] MenzinJ, Korn, J, Cohen, J, et.al Relationship between glycemic control and diabetes related hospital costs in patients with type 1 or type 1 diabetes mellitus. J Manag Care Pharm. 2010; 16(4):264-275.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

139485012.3.9	*3.IT-1.10*	*Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure)*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2. An initial data analysis from our E.H.R shows that at least 17.4% of patients at the Baylor Clinic at Baylor University Medical Center have an HbA1c > 9.0%* ***Target Population:*** *Uninsured/undeserved patients in Dallas County with an HbA1c > 9.0%*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
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 reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 63,699 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 63,699	**Outcome Improvement Target 1** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure) Improvement Target: ≤16.5% (or minimum of 0.9% reduction over baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 114,854	**Outcome Improvement Target 2** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure) Improvement Target: ≤15.7% (or minimum of 1.7% reduction over baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment: $ 184,301	**Outcome Improvement Target 3** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Standalone measure) Improvement Target: ≤14.9% (or minimum of 2.5% reduction over baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 440,722
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):$ 127,398	Year 3 Estimated Outcome Amount: $ 114,854	Year 4 Estimated Outcome Amount: $ 184,301	Year 5 Estimated Outcome Amount: $ 440,722
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 867,275			

Title of Outcome Measure (Improvement Target): IT-1.11 Diabetes Care: BP control (<140/80 mmHg) NQF 0061 (Standalone measure)

Unique RHP Outcome Identification Number: 139485012.3.10

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Measure Description

IT-1.11 Diabetes care: *BP control (<140/80mm Hg)- (Standalone measure)*

- Numerator: Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg.
- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

By the end of the waiver, our goal is to have > 49.4% (or 7.2% improvement over baseline) of patients 18-75 years old with diabetes (type 1 or type 2) under BP control (< 140/80 mmHg). This is a 7.2% improvement over baseline. This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program for at least 6 months. Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish Baseline Rates
    - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows that at least 49.4% of patients with diabetes at the Baylor Clinic at Baylor University Medical Center have BP less than 130/80 mmHg. At Baylor University Medical Center Medical Center, we have been historically defining uncontrolled BP > 130/80 mmHg, we will have to adjust our tracking for this project.

Outcome Improvement Targets for each year

- DY3:
  - IT-1.11: Diabetes Care: BP control (<140/80 mmHg)

        - Our goal is increase the % of patients in good BP control (<140/80 mmHg) to 51.9% (or 2.5% improvement over baseline) of patients at the Baylor Clinic who have engaged in the chronic care management program
- DY4:
    - IT-1.11: Diabetes Care: BP control (<140/80 mmHg)
        - Our goal is increase the % of patients in good BP control (<140/80 mmHg) to 54.3% (or 4.9% improvement over baseline) (or of patients at the Baylor Clinic who have engaged in the chronic care management program
- DY5:
    - IT-1.11: Diabetes Care: BP control (<140/80 mmHg)
        - Our goal is increase the % of patients in good BP control (<140/80 mmHg) to 56.6% (or 7.2% improvement over baseline) of patients at the Baylor Clinic who have engaged in the chronic care management program

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

We will have to review our baseline numbers in DY2. Historically, in our E.H.R we have been tracking BP control as < 130/80 mmHg. In order to meet the requirements of this project, we will have to re-analyze the numbers and re-establish our new baseline.
As part of the standard of care for diabetes management, optimal blood pressure control is an included component of this protocol. At Baylor Health Care System, blood pressure control and management is a required part of the diabetes care bundle in order to avoid other co-morbid conditions such as heart disease and stroke. A 2010 study in the New England Journal of Medicine by Cushman, et. al showed that better and less severe health outcomes related to cardiovascular episodes and stroke were achieved with tight blood pressure control in diabetic patients[509]. Events that would be fatal with higher blood pressure became nonfatal under better blood pressure control in these studies completed. As part of an outpatient, clinic-based protocol, blood pressure control can be achieved in patients who will come to the Baylor Clinic as part of the primary care expansion project.

Outcome Measure Valuation

[509] Cushman WC, Evans, GW, et. al Effects of intensive blood pressure control in type 2 diabetes mellitus. N Engl J Med. 2010. Apr 29; 362(17): 1575-85

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

139485012.3.10	*3.IT-1.11*	*Diabetes Care: BP control (<140/80 mmHg)*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 and redefined as <140/80 mmHg. Currently, we have about 49.4% of our patients that have a BP < 130/80 mmHg at the Baylor Clinic at Baylor University Medical Center.* ***Target Population:*** *Underserved/uninsured diabetic patients with BP >140/80 mmHg in Dallas County*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 15,424 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $15,425	**Outcome Improvement Target 1** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Standalone measure) Improvement Target: > 51.9% (or 2.5% improvement over baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 114,854	**Outcome Improvement Target 2** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Standalone measure) Improvement Target: > 54.3% (or 4.9% improvement over baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 184,301	**Outcome Improvement Target 3** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Standalone measure) Improvement Target: > 56.6% (or 7.2% improvement over baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 440,721
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 31,849	Year 3 Estimated Outcome Amount: $ 114,854	Year 4 Estimated Outcome Amount: $ 184,301	Year 5 Estimated Outcome Amount: $ 440,721
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 771,725			

Title of Outcome Measure (Improvement Target): IT-1.13 Diabetes Care: Diabetes care: Foot exam- NQF 0056

Unique RHP Outcome Identification Number: 139485012.3.11

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Measure Description

IT-1.13 Diabetes care *Foot exam- (Non- standalone measure)*

- 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).

By the end of the waiver, our goal is to have > 90.4% (or 3.6% improvement over baseline) of patients 18-75 years old with diabetes (type 1 or type 2) receive a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year(s). This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish Baseline Rates
    - We will confirm and establish our baseline. A preliminary E.H.R data analysis shows 86.8% of diabetic patients that are seen by a diabetes educator at the Baylor Clinic at Baylor University Medical Center receive a foot exam

Outcome Improvement Targets for each year

- DY3:
  - IT-1.13: Diabetes Care: Foot exam
    - Our goal is to increase this rate to at least 88.1% (or 1.3% improvement over baseline) of diabetic patients receiving a foot exam
- DY4:
  - IT-1.13: Diabetes Care: Foot exam

        - Our goal is to increase this rate to at least 89.3% (or 2.5% improvement over baseline) of diabetic patients receiving a foot exam
- DY5:
    - IT-1.13: Diabetes Care: Foot exam
        - Our goal is to increase this rate to at least 90.4% (or 3.6% improvement over baseline) of diabetic patients receiving a foot exam

Rationale

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical data from similar programs that showed material improvement in a 2-3 year time period.

An innovative part of this project is that the educators (CHWs and RN Care Managers) will be able to conduct diabetic foot exams as part of their education session with their patients. This will increase the rate of screening and allow these providers to identify issues such as ulcers and nerve issues earlier and more often. Foot exams are a low cost, highly effective way to avoid costly interventions such as wound care and management, amputations, neuropathy and other complex issues. This is better utilization and management of resources through early identification and prevention of serious diabetes foot related issues. It is recommended by the American Diabetes Association that diabetic patients receive yearly foot exams to determine if there are predisposing factors for ulceration and amputation.[510]

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

[510] American Diabetes Association: http://www.ada.org

Related Category 1 and/or 2 projects

139485012.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

139485012.3.11	*3.IT-1.13*	*Diabetes Care: Foot Exam*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2. An initial data analysis from our E.H.R shows that about 86.8% of diabetic patients seen by a diabetes educator at the Baylor Clinic at Baylor University Medical Center Medical Center receive a foot exam* ***Target Population:*** *Underserved/uninsured patients with diabetes in Dallas County*		
Year 2 (10/1/2012 – 9/30/2013)	**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-3.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 31,849 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 31,849	**Outcome Improvement Target 1** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Standalone measure) Improvement Target: >88.1% (or 1.3% improvement over baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 28,381	**Outcome Improvement Target 2** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Standalone measure) Improvement Target: >89.3% (or 2.5% improvement over baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 46,075	**Outcome Improvement Target 3** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Standalone measure) Improvement Target: >90.4% (or 3.6% improvement over baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 110,180
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 63,699	Year 3 Estimated Outcome Amount: $ 28,713	Year 4 Estimated Outcome Amount: $ 46,075	Year 5 Estimated Outcome Amount: $ 110,180
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 248,667			

Title of Outcome Measure (Improvement Target): IT-11.1 Improvement in Clinical Indicator in Identified Disparity Group. Clinical indicator to be improved and disparity group to be determined by provider.

Unique RHP Outcome Identification Number: 139485012.3.12

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Measure Description

IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider *(Standalone measure)*

- Numerator: Number of patients with an improved Diabetes POA (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter
- Denominator: Total number of patients with a Behavioral Health intervention/ encounter

One of the outcome measures we have chosen for our behavioral health program is to improve Baylor's standard diabetes Percent of Opportunities Achieved (POA) which consists of HbA1c, LDL, BP control for patients who have engaged in our behavioral health program. POA is similar in nature to an improvement bundle, but differs slightly in the way it is calculated. Here, we define the disparate population as the underserved individuals in Dallas County that have both a diagnosis of diabetes and a behavioral health issue.

By the end of the waiver, our goal is to have > 15% of patients who have had a behavioral health intervention/encounter to have improvement in our Diabetes POA (HbA1c, LDL, BP, etc) that have uncontrolled values for these measures and have an identified behavioral health issue.

- HbA1c < 8%
- LDL < 100
- BP < 130/80 mmHg

Baylor's standard diabetes POA (HbA1c, LDL, BP) is measured by using percent of opportunities achieved (POA). We plan on measuring the improvement in Diabetes for Baylor Clinic patients that receive behavioral health treatment. The Diabetes POA which consists of: LDL, BP and HbA1c control is measured yearly for our diabetic patients. The POA is calculated by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population.

POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in diabetes management POA from 50% to 60% within a population means

the clinic was successful in achieving 10% more processes/targets for their diabetes patients than in the prior reporting period.

For an illustrative example: For Diabetes- there are 3 opportunities (i.e. metrics) per patient (1) A1c < 8, 2) LDL < 100, 3) BP < 130/80 mmHg). The denominator would be # of patients x 3. So, for example, if there are 10 patients x 3 opportunities each = 30 opportunities to be achieved. If, in the course of the year, only 20 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 20/30=67%. To achieve a 10% improvement in POA, we would have to have completed at least 23/30 opportunities to get at 77% achievement.

We define this outcome in the following way:
Numerator: Number of patients with an improved Diabetes POA (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter
Denominator: Total number of patients with a Behavioral Health intervention/ encounter

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish Baseline Rates
    - We will establish a baseline of current status of the Diabetes POA for patients that have a reported behavioral health issue
- DY3:
  - P-2: Establish Baseline Rates
    - We will compare the DY2 baseline rate to results in DY3 to measure change refine data collection processes if necessary

Outcome Improvement Targets for each year

- DY3:
  - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Diabetes Percent of Opportunities Achieved in Behavioral Health patients)
    - We will improve the Diabetes POA for 5% of patients who have had at least one behavioral health intervention/encounter in one year
- DY4:
  - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Diabetes Percent of Opportunities Achieved in Behavioral Health patients)
    - We will improve the Diabetes POA for 10% of patients who have had at least one behavioral health intervention/encounter in one year

- DY5:
    - IT-11.1 Improvement in Clinical Indicator in identified disparity group (Diabetes Percent of Opportunities Achieved in Behavioral Health patients
        - We will improve the Diabetes POA for 15% of patients who have had at least one behavioral health intervention/encounter in one year

Rationale

Category 3 metrics for this project were identified using literature only. Baylor has had no previous experience with a behavioral health program of this nature. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting.

Our main goal by selecting this outcome was to recognize and increase awareness of patients who have co-occurring behavioral health and diabetes health issues. By recognizing this, we believe we can positively impact diabetes outcomes by addressing underlying behavioral health issues that patients may have.

In DY2, we will collect our baseline information about the status of the Diabetes POA (HbA1c, LDL, BP) for patients who have a documented behavioral health issue. The problem with this collection is that because this program is new, both patients and clinicians are not actively looking for and documenting behavioral health problems that patients have. As part of our project, we plan to increase screenings using PHQ2/9, GAD-7 and substance abuse tools but until that is implemented, the numbers we will be reporting for baseline will be underreported. Once there is more awareness about the screenings and program, we anticipate that more patients will disclose their behavioral health issue and their providers will also be more aware of these conditions.

We believe if we increase the treatment rates of behavioral health issues, that we will also see an increase in patient compliance rates with other preventive screening/testing and clinical recommendations made by their providers.
In Region 9, there is a 36% increase in average charges per encounter for those individuals with a co-occurring behavioral health issue and chronic disease. 100% of the frequent flyers had a co-occurring mental illness and cost the Region over $26 million dollars.[511]

A recent study conducted in early 2012, by Jeffery Johnson, et. al showed a direct correlation between diabetes and depression. They cited that depression is the most common co-morbid condition present in 15-30% of patients with Type 2 diabetes and less than 50% are recognized as having depression. Depression is associated with poorer self care behaviors, decreased quality of life and substantially higher health care costs. Both diabetes and behavioral health

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issues are prevalent across the region, warranting measurement of the efficacy of a behavioral health program on chronic diseases.[512]

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.2.2: Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment

[512] Johnson, JA, Sayah, FA, et.al. Controlled trial of a collaborative primary care team model for patients with diabetes and depression: rationale and design for a comprehensive evaluation. BMC Health Services Research. 2012, 12:358

139485012.3.12	*IT-11.1*	*Improvement in clinical indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider- Diabetes POA improvement*		
Baylor University Medical Center				*139485012*
Related Category 1 or 2 Projects:		*139485012.2.2- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:		***Definition of Metric**:* *Numerator: Number of patients with an improved Diabetes Percent of Opportunities Achieved (POA) improvement (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter* *Denominator: Total number of patients with a Behavioral Health intervention/encounter* ***Baseline:** The baseline for Baylor University Medical Center will be established in DY2.* ***Target Population:** On average, 15-30% of patients with Diabetes have a co-morbid behavioral health diagnosis (usually Depression), which would mean approximately 41,000 to 82,000 people*		
Year 2 (10/1/2012 – 9/30/2013)		**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 Goal: Complete planning processes for behavioral health program Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 53,734 **Process Milestone 2** [P-2]: Establish baseline rates Metric: Determine current status of patients with co-occurring illnesses Goal: Determine number of patients with out of range Diabetes POA (HbA1c, LDL, BP) that have a documented		**Process Milestone 3** [P-2]: Establish baseline rates Metric: Compare DY2 baseline assessment of patients with uncontrolled Diabetes POA and documented behavioral health issues to DY3 data period Goal: Determine if more self or clinician reported data around identification of behavioral health issues has an impact on DY2 baseline reporting Data Source: E.H.R Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 62,285 **Outcome Improvement Target 1** [IT-11.1]: Improve Clinical Indicator in identified disparity group. Improvement Target: Improve Diabetes POA (HbA1c, LDL, BP) for at least 5% of patients who have had at least 1 behavioral health	**Outcome Improvement Target 2** [IT-11.1]: Improve Clinical Indicator in identified disparity group. Improvement Target: Improve Diabetes POA (HbA1c, LDL, BP) for at least 10% of patients who have had at least 1 behavioral health encounter/intervention Numerator: # of patients with improved Diabetes POA Denominator: # of patients with at least 1 behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 266,521	**Outcome Improvement Target 3** [IT-11.1]: Improve Clinical Indicator in identified disparity group. Improvement Target: Improve Diabetes POA (HbA1c, LDL, BP) for at least 15% of patients who have had at least 1 behavioral health encounter/intervention Numerator: # of patients with improved Diabetes POA Denominator: # of patients with at least 1 behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 637,333

139485012.3.12	*IT-11.1*	*Improvement in clinical indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider- Diabetes POA improvement*		
Baylor University Medical Center				*139485012*
Related Category 1 or 2 Projects:		*139485012.2.2- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:		***Definition of Metric**:* *Numerator: Number of patients with an improved Diabetes Percent of Opportunities Achieved (POA) improvement (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter* *Denominator: Total number of patients with a Behavioral Health intervention/encounter* ***Baseline:** The baseline for Baylor University Medical Center will be established in DY2.* ***Target Population:** On average, 15-30% of patients with Diabetes have a co-morbid behavioral health diagnosis (usually Depression), which would mean approximately 41,000 to 82,000 people*		
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
behavioral health issue Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 53,734		encounter/intervention Numerator: # of patients with improved Diabetes POA Denominator: # of patients with at least 1 behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 62,285		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 107,468		Year 3 Estimated Outcome Amount: $ 124,570	Year 4 Estimated Outcome Amount: $ 266,521	Year 5 Estimated Outcome Amount: $ 637,333
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 1,135,892				

Title of Outcome Measure (Improvement Target): IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services and treatment) in target population with identified disparity. (**Non-standalone measure**)

Unique RHP Outcome Identification Number: 139485012.3.13

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Measure Description

IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services and treatment) in target population with identified disparity. *(Non-standalone measure)*

- Numerator: patients who are Baylor clinic patient who engage in a behavioral health treatment/intervention
- Denominator: patients who are Baylor clinic patients who are eligible for behavioral health services

One of the outcome measures we have chosen for our behavioral health program is to increase the number of patients in the underserved population who have improved utilization rates for receiving behavioral health treatments/interventions. The subset of the target population that suffers from mental health issues is prevalent in the region. Only 19.8% of underserved patients receive behavioral treatment in the same setting as their primary care.[513] The disparate population that we will be focusing on is the underserved/uninsured patients in Dallas County with behavioral health needs.

By the end of the waiver, our goal is to have > 20% of patients who are eligible to participate in the behavioral health program, engage in the program.

We define this outcome in the following way:

Numerator: patients who are Baylor clinic patient who engage in a behavioral health treatment/intervention
Denominator: patients who are Baylor clinic patients who are eligible for behavioral health services

The idea of this metric is that by engaging patients in behavioral health treatment/ interventions that their subsequent medical care will also improve. Patients who engage are those who have had at least two behavioral health interventions/encounters in the past 12 months. Patients eligible for behavioral health entail those that have 1) been identified through the PHQ2/9, GAD-7 and Substance Abuse screening tools that are in need of intervention, 2) self- identified need or 3) provider/clinician identification of patient need for behavioral health counseling. This Outcome Measure is different than the Improvement Milestone we proposed

[513] RHP 9 Community Health Needs Assessment

in our Category 2 Project Table because Outcome Measure 11.3 focuses on utilization of the behavioral health service, entailing that an "engaged" patient is one that has had at least two behavioral health encounters/interventions in the past 12 months. The Improvement Milestone in the project table is a volume metric focused on enrolling the patient in a Behavioral Health program. This Outcome Measure takes this one step further by requiring at least two visits in the past 12 months.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish Baseline Rates
    - We will establish a baseline of how many patients have a behavioral health issue (substance abuse, anxiety, depression, other) based on our E.H.R, self-reported or clinician reported status.
- DY3:
  - P-2: Establish Baseline Rates
    - We will compare our DY2 baseline analysis to DY3 to determine if any improvements need to be made to the data collection process and to capture any variances between the two data sets

Outcome Improvement Targets for each year

- DY3:
  - IT-11.3: Improve utilization rates of clinical preventive services
    - We will improve behavioral health treatment rates by 10%
- DY4:
  - IT-11.3: Improve utilization rates of clinical preventive services
    - We will improve behavioral health treatment rates by 15%
- DY5:
  - IT-11.3: Improve utilization rates of clinical preventive services
    - We will improve behavioral health treatment rates by 20%

Rationale

Category 3 metrics for this projects were identified using literature only. Baylor has had no previous experience with a behavioral health program of this nature. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting.

Our main goal by selecting this outcome was to demonstrate increased access and utilization of the behavioral health program we are proposing.
In DY2, we will collect our baseline information about the number of patients who have a behavioral health issue. The problem with this collection is that because this program is new, both patients and clinicians are not actively looking for and documenting behavioral health problems that patients have. As part of our project, we plan to increase screenings using PHQ2/9, GAD-7 and substance abuse tools but until that is implemented, the numbers we will be reporting for baseline will be underreported. Once there is more awareness about the screenings and program, we anticipate that more patients will disclose their behavioral health issue and their providers will also be more aware of these conditions.

We believe if we increase the treatment rates of behavioral health issues, that we will also see an increase in patient compliance rates with other preventive screening/testing and clinical recommendations made by their providers.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects
139485012.2.2: Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment

139485012.3.13	*3.IT-11.3*	*Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. The disparate population is the underserved/uninsured patients with behavioral health issues.*
Baylor University Medical Center		*139485012*
Related Category 1 or 2 Projects:	*139485012.2.2: Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*	
Starting Point/ Baseline:	***Baseline:*** *The baseline for Baylor University Medical Center will be established in DY2.* ***Target Population:*** *The target population in the Dallas county area is over 200,000 underserved individuals who suffer from a mental illness*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 53,734 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 53,734	**Process Milestone 3** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 3 Estimated Incentive Payment: $ 62,285 **Outcome Improvement Target 1** [IT-11.3]: Improve utilization rates of clinical preventive services Improvement Target: Increase rate of patient engagement by 10% Numerator: # of patients engaged in behavioral health treatment/intervention Denominator: # of patients eligible for behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 62,285	**Outcome Improvement Target 2** [IT-11.3]: Improve utilization rates of clinical preventive services Improvement Target: Increase rate of patient engagement by 15% Numerator: # of patients engaged in behavioral health treatment/intervention Denominator: # of patients eligible for behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 133,261	**Outcome Improvement Target 3** [IT-11.3]: Improve utilization rates of clinical preventive services Improvement Target: Increase rate of patient engagement by 20% Numerator: # of patients engaged in behavioral health treatment/intervention Denominator: # of patients eligible for behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 318,666
Year 2 Estimated Outcome Amount: $ 107,468	Year 3 Estimated Outcome Amount: $ 124,570	Year 4 Estimated Outcome Amount: $ 133,261	Year 5 Estimated Outcome Amount: $ 318,666
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 683,965			

Title of Outcome Measure (Improvement Target): IT-5.1 Improved Cost Savings: Demonstrate cost savings in care delivery (Non-Standalone measure)

Unique RHP Outcome Identification Number: 139485012.3.14

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Measure Description

IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (*Standalone measure for Project 2.5 only. For all other projects –Non- standalone measure)*

- Type of analysis to be determine by provider from the following list: Cost of Illness Analysis, Cost Minimization Analysis, Cost Effectiveness Analysis (CEA), Cost Consequence Analysis, Cost Utility Analysis, Cost Benefit Analysis

By the end of the waiver, our goal is to have > 30% cost savings in health care services utilization (through fewer ED visits and less overall utilization) for patients who have engaged in our care navigation program and have a confirmed appointment with a PCP/PCMH.

One of the outcome measures we have chosen for our care navigation program is to improve cost savings in the healthcare delivery system for those patients that have been served by the care navigation program.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish Baseline Rates
        - In DY2 we will establish a baseline of average cost savings incurred by patients who have been seen by the care navigation program while in the ED and have a confirmed appointment with a PCP/PCMH. We will compare pre and post utilization patterns of enrolled patients to determine the total cost savings incurred (inpatient and outpatient) per patient. For example, if prior to being seen by our care navigation program, a patient's total cost utilization was $10,000 we anticipate that after being connected to the appropriate resource and being seen for an appointment that over the course of 1 year, total costs would decrease by 20% (DY4) to $8,000.

Outcome Improvement Targets for each year

- DY3:
    - IT-5.2: Improved Cost Savings
        - We aim to improve cost savings for those patients that have been 1) seen by our care navigation and program and 2) have a confirmed appointment by 15% using a pre/post analysis of utilization patterns for total cost of care over the course of 1 year
- DY4:
    - IT-5.2: Improved Cost Savings
        - We aim to improve cost savings for those patients that have been 1) seen by our care navigation and program and 2) have a confirmed appointment by 20% using a pre/post analysis of utilization patterns for total cost of care over the course of 1 year
- DY5:
    - IT-5.2: Improved Cost Savings
        - We aim to improve cost savings for those patients that have been 1) seen by our care navigation and program and 2) have a confirmed appointment by 25% using a pre/post analysis of utilization patterns for total cost of care over the course of 1 year

Rationale

In DY2, we plan to do some in depth utilization analysis to determine a baseline of what the cost utilization patterns are for patients seen at Baylor University Medical Center. This, based on our historical experience with similar programs on other campuses, we anticipate a 15%, 20% and 25% cost savings over the subsequent years in total cost of care savings.

The reason we chose this metric is because financial constraints are a main concern for the Region in being able to provide high quality care to the underserved population. Cost savings and effectiveness are a key part of the overall Waiver and require providers to be good stewards of their resources. This metric is appropriate because it emphasizes appropriate utilization of resources and reinforces the concept of cost effectiveness. We plan to measure the cost effectiveness and cost utilization of this project. According to the Texas Medical Association, the cost of treating a condition that could be treated in the doctor's office for $56.21 (including lab and x-ray) costs $193.92 in the Emergency room[514]. This cost differential multiplied by the 443,000 uninsured in Dallas County creates a significant cost to the county and Region.

Outcome Measure Valuation

[514] Texas Medical Association: http://www.texmed.org

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect

139485012.3.14	*3.IT-5.1*	*Improved cost savings: demonstrate cost savings in care delivery*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor University Medical Center will be established in DY2. Typical costs for an inpatient stay for an uninsured patient is $19,400* ***Target Population:*** *Underserved/uninsured patients without a PCP/PCMH in Dallas County.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 50,936 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 50,937	**Outcome Improvement Target 1** [IT-5.1]: Improved Cost Savings Improvement Target: For patients that have been seen by the care navigation program, have a confirmed PCP/PCMH appointment, cost savings should be 15% in a pre-post utilization analysis Data Source: E.H.R/Care Navigation database Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 78,722	**Outcome Improvement Target 2** [IT-5.1]: Improved Cost Savings Improvement Target: For patients that have been seen by the care navigation program, have a confirmed PCP/PCMH appointment, cost savings should be 20% in a pre-post utilization analysis Data Source: E.H.R/Care Navigation database Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 126,322	**Outcome Improvement Target 3** [IT-5.1]: Improved Cost Savings Improvement Target: For patients that have been seen by the care navigation program, have a confirmed PCP/PCMH appointment, cost savings should be 25% in a pre-post utilization analysis Data Source: E.H.R/Care Navigation database Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 302,074
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 101,873	Year 3 Estimated Outcome Amount: $ 78,722	Year 4 Estimated Outcome Amount: $ 126,322	Year 5 Estimated Outcome Amount: $ 302,074
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 608,991			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization (**Standalone measure**)

Unique RHP Outcome Identification Number: 139485012.3.15

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Measure Description

IT-9.2 ED appropriate utilization *(Standalone measure)*

- Reduce all ED visits (including ACSC)
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)-N/A
- Reduce Emergency Department visits for target conditions
    - Congestive Heart Failure
    - Diabetes
    - End Stage Renal Disease
    - Cardiovascular Disease/Hypertension
    - Behavioral Health/Substance Abuse
    - Chronic Obstructive Pulmonary Disease
    - Asthma

By the end of the waiver, our goal is to have > 35% reduction in inappropriate ED utilization for all causes and > 20% reduction in inappropriate ED utilization for targeted conditions: CHF, Diabetes, ESRD, CVD/Hypertension, Behavioral Health/Substance Abuse, COPD and Asthma

One of the outcome measures we have chosen for our care navigation program is to reduce ED utilization. The protocol mentions three parts to this metric:

7) Reduce all ED visits (including ACSC)
8) Reduce pediatric Emergency Department visits (CHIPRA Core Measure)-*we will not be measuring this outcome as we do not see pediatric patients at Baylor University Medical Center*
9) Reduce ED visits for target conditions
    a. CHF
    b. Diabetes
    c. ESRD
    d. CVD/Hypertension
    e. Behavioral Health/Substance Abuse
    f. COPD

g. Asthma

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3: Establish Baseline Rates
    - We will establish a baseline for the aforementioned components of the improvement metric (less #2- pediatric ED visits) and determine the full opportunity for improvement
- DY3:
  - P-3 Establish Baseline Rates
    - We will conduct a comparison between DY2 and DY3 to determine the change in rates for ED utilization and utilization of targeted conditions and determine any seasonality or variations in data collection/trends

Outcome Improvement Targets for each year

- DY3:
  - IT-9.2: ED Appropriate Utilization
    - We aim to reduce all ED visits by 25% and ED visits for targeted conditions by 10%
- DY4:
  - IT-9.2: ED Appropriate Utilization
    - We aim to reduce all ED visits by 30% and ED visits for targeted conditions by 15%
- DY5:
  - IT-9.2: ED Appropriate Utilization
    - We aim to reduce all ED visits by 35% and ED visits for targeted conditions by 20%

Rationale

Baylor University Medical Center sees very few children, thus metric 2 is not applicable to this project. We do not see enough pediatric patients to make a material impact on the ED utilization rate for this population. Historically, we have not tracked the ED utilization for targeted conditions (i.e. CHF, Diabetes, etc), for this type of project thus we do not have a

baseline measurement for these specific diseases. We plan to measure these in DY2 and DY3 and target a modest improvement of ED utilization in the subsequent years.

According to the Community Health Needs Assessment of Region 9, 68% of ED visits were preventable/ treatable in an outpatient setting[515]. The stakeholder survey conducted amongst performing providers also indicated that there is a significant overuse of emergency department services due to patients' inability to access primary care. This metric is at the heart of the care navigation project we are proposing and will have a direct impact on patients in Dallas County utilizing the ED at a decreased rate. This project uses the popular concept created by Dr. Atul Gawande, referred to as "hot spotting" indicating a focus on finding the high risk/high utilization rates of the ED and determining the root cause for these visits, and then working to remedy those issues[516]. Issues such as transportation, navigation of community and appropriate resources are just two examples that can lead to more effective use of the ED.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect

[515] RHP 9 Community Health Needs Assessment

[516] Gawande, A. The hot spotters: can we lower medical costs by giving the neediest patients better care? The New Yorker. (2011).

139485012.3.15	*3.IT-9.2*	*ED Appropriate Utilization*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.2.3- Establish/Expand a Patient Care Navigation Program-Care Connect*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor University Medical Center will be established in DY2. Based on historical performance of similar programs, ED utilization typically decreased by 30% in the first year.* ***Target Population:*** *Underserved/uninsured patients without a PCP/PCMH that are frequent users of the ED*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 50,937 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 50,938	**Process Milestone 3** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 78,725 **Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED Utilization for All ED Visits by 25% for those patients who have been served by the care navigation program and have a confirmed appointment with the PCP/PCMH Improvement Target: Reduce ED utilization for patients with targeted conditions (CHF, Diabetes, etc) that have been served by the care navigation program and have a confirmed appointment with a PCP/PCMH by 10% Data Source: E.H.R/Care Navigation database Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 78,725	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED Utilization for All ED Visits by 30% for those patients who have been served by the care navigation program and have a confirmed appointment with the PCP/PCMH Improvement Target: Reduce ED utilization for patients with targeted conditions (CHF, Diabetes, etc) that have been served by the care navigation program and have a confirmed appointment with a PCP/PCMH by 15% Data Source: E.H.R/Care Navigation database Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 252,645	**Outcome Improvement Target 3** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED Utilization for All ED Visits by 35% for those patients who have been served by the care navigation program and have a confirmed appointment with the PCP/PCMH Improvement Target: Reduce ED utilization for patients with targeted conditions (CHF, Diabetes, etc) that have been served by the care navigation program and have a confirmed appointment with a PCP/PCMH by 20% Data Source: E.H.R/Care Navigation database Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 604,150

139485012.3.15	*3.IT-9.2*	*ED Appropriate Utilization*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.2.3- Establish/Expand a Patient Care Navigation Program-Care Connect*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor University Medical Center will be established in DY2. Based on historical performance of similar programs, ED utilization typically decreased by 30% in the first year.* ***Target Population:*** *Underserved/uninsured patients without a PCP/PCMH that are frequent users of the ED*		
Year 2 (10/1/2012 – 9/30/2013)	**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): $ 101,875	Year 3 Estimated Outcome Amount: $ 157,450	Year 4 Estimated Outcome Amount: $ 252,645	Year 5 Estimated Outcome Amount: $ 604,150
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 1,116,120			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life

Unique RHP Outcome Identification Number: 139485012.3.16

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Description:

IT-10.1: Quality of Life *(Standalone measure)*

Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.

By the end of the waiver, our goal is to improve the mean score (average change from patient enrollment to most recent survey) on Quality of Life assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 7% over DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will determine the Quality of Life tool that will be used for this outcome
    - P-2: Establish baseline rates
        - We will confirm and establish our baseline. We do not currently utilize Quality of Life surveys. In a transitional care program for the elderly currently in existence at Baylor Health Care System, clinicians site that that Quality of Life indicators such as depression and cognition exams improve over time with home visits.

Outcome Improvement Targets for each year

- DY3:
    - IT-1.10: Quality of Life (Standalone)
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Quality of Life assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 3% over DY2.

- DY4:
    - IT-1.10: Quality of Life (Standalone)
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Quality of Life assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 5% over DY2.
- DY5:
    - IT-1.10: Quality of Life (Standalone)
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Quality of Life assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 7% over DY2.

Rationale

Quality of Life assessments such as the SF-36 or AQoL measure components such as: illness, independent living, social relationships, physical senses and psychological wellbeing and will be important to measure in the high risk and vulnerable patients we intend to serve.[517] Understanding social and physical attributes of the patient will be essential in determining their feasibility of following protocols and regimens that will optimize their healthcare. We plan on conducting a QOL assessment every 6 months on patients who have been in the program for at least 6 months. Improvement will be measured from the time the patient is enrolled to time of survey administration.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

[517] Hawthorne, G. The assessment of quality of life instrument: a psychometric measure of health related quality of life. *Qual Life Res.*8(3):209-24 (1999)

Related Category 1 and/or 2 projects

139485012.2.4-Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)

139485012.3.16	*3.IT-10.1*	*Quality of Life*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.2.4– Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)*		
Starting Point/Baseline:	***Baseline:*** *Baseline will be established in DY2. We do not currently track ADL assessments and improvements.* ***Target Population:*** *High risk, vulnerable patients who are unable to access care in an ambulatory care setting. The top 5% of high risk uninsured and Medicaid patients from the 872,000 uninsured in Dallas County.*		
Year 2 (10/1/2012 – 9/30/2013)	**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-1.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports and Quality of Life assessment tool Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $34,478 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $34,478	**Outcome Improvement Target 1** [IT-10.1]: Quality of Life (Standalone) Improvement Target: > 3% improvement in mean Quality of Life scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $86,883	**Outcome Improvement Target** IT-10.1]: Quality of Life (Standalone) Improvement Target: > 5% improvement in mean Quality of Life scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $139,417	**Outcome Improvement Target 3** IT-10.1]: Quality of Life (Standalone) Improvement Target: > 7% improvement in mean Quality of Life scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 333,389
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 74,955	Year 3 Estimated Outcome Amount: $86,883	Year 4 Estimated Outcome Amount: $139,417	Year 5 Estimated Outcome Amount: $333,389
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 634,644			

Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living

Unique RHP Outcome Identification Number: 139485012.3.17

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Description:

IT-10.2: Activities of Daily Living *(Standalone measure)*

Demonstrate improvement in ADL scores, as measured by evidence based and validated assessment tool, for the target population.

By the end of the waiver, our goal is to improve the mean score (average change from patient enrollment to most recent survey) on Activities of Daily Living assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 7% over DY2.

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
        - We will determine the Activities of Daily Living tool that will be used for this outcome
    - P-2: Establish baseline rates
        - We will confirm and establish our baseline. In a transitional care program for the elderly currently in existence at Baylor Health Care System, clinicians site that ADL improvement in the elderly population improves where patients go from partial dependence to independence.

Outcome Improvement Targets for each year

- DY3:
    - IT-10.2: Activities of Daily Living *(Standalone measure)*
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Activities of Daily Living assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 3% over DY2.

- DY4:
    - IT-10.2: Activities of Daily Living *(Standalone measure)*
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Activities of Daily Living assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 5% over DY2.
- DY5:
    - IT-10.2: Activities of Daily Living *(Standalone measure)*
        - Our goal is to increase the mean score (average change from patient enrollment to most recent survey) on Activities of Daily Living assessments for patients who have been in the Vulnerable Patient Network (Home Visits) program for at least 6 months at the time of survey administration by at least 7% over DY2.

Rationale

Measurement of the activities of daily living is critical because they have been found to be significant predictors of paid home care , use of hospital services, living arrangements, use of physician, insurance coverage and mortality.[518] While ADLs are typically used with the elderly population, the complexity and nature of the high risk uninsured/Medicaid patients warrants this assessment as well. Monitoring the progress or decline of factors such as bathing, feeding, continence, transferring, toileting and dressing are immediate predictors of any issues or barriers that patients may be experiencing.[519] We may need to consider using the Lawton IADL scale for this population as it involves more complex activities such as: shopping, laundry, responsibility for own medications, etc.[520] We plan on conducting the ADL assessment every 6 months and patients that have been in the program for 6 months. The improvement will be measured from the time that patients enroll in the program to survey conduction.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and

[518] Measuring ADLs Across National Surveys: http://aspe.hhs.gov/daltcp/reports/meacmpes.htm

[519] Katz, Sidney. 1983. "Assessing Self-Maintenance: Activities of Daily Living, Mobility, and Instrumental Activities of Daily Living." *Journal of the American Geriatrics Association* 31:721-727.

[520] Lawton, M. Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living. *The Gerontologist* 9:179-186.

hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.2.4-Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)

139485012.3.17	*3.IT-10.2*	*Activities of Daily Living*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.2.4– Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)*		
Starting Point/Baseline:	***Baseline:*** *Baseline will be established in DY2. We do not currently track ADL assessments and improvements.* ***Target Population:*** *High risk, vulnerable patients who are unable to access care in an ambulatory care setting. The top 5% of high risk uninsured and Medicaid patients from the 872,000 uninsured in Dallas County.*		

Year 2 (10/1/2012 – 9/30/2013)	**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-1.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports. Documentation of ADL assessment tool chosen Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 37,478 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 37,478	**Outcome Improvement Target 1** [IT-10.2]: Quality of Life (Standalone) Improvement Target: > 3% improvement in mean ADL scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 86,883	**Outcome Improvement Target** [IT-10.2]: Quality of Life (Standalone) Improvement Target: > 5% improvement in mean ADL scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $139,418	**Outcome Improvement Target 3** [IT-10.2]: Quality of Life (Standalone) Improvement Target: > 7% improvement in mean ADL scores for patients in program for at least 6 months Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $ 333,388
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 74,956	Year 3 Estimated Outcome Amount: $ 86,883	Year 4 Estimated Outcome Amount: $139,418	Year 5 Estimated Outcome Amount: $ 333,388
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 634,645			

Title of Outcome Measure (Improvement Target): IT-1.2 Annual monitoring for patients on persistent medication– angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (*Non- standalone measure*)

Unique RHP Outcome Identification Number: 139485012.3.18

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Description:

IT-1.2: Annual monitoring for patients on persistent medications angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (*Non- standalone measure*)

Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
Percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Since we do not have a baseline for patients receiving a serum potassium, serum creatinine or blood urea nitrogen test during the measurement year, we are proposing the following tiers of improvement:

- If 25-50% of patients on an ACE/ARB inhibitor are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 5% in DY3, 10% in DY4 and 15% in DY5 (all over DY2 baseline)
- If 50-75% of patients on an ACE/ARB inhibitor are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 5% in DY3, 7% in DY4 and 9% in DY5 (all over DY2 baseline)
- If 75-90% patients on an ACE/ARB inhibitor are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 2% in DY3, 4% in DY4 and 6% in DY5 (all over DY2 baseline)
- If 90% or more patients on an ACE/ARB inhibitor are receiving a serum potassium/creatinine or BUN test within one year then we will not pursue this outcome improvement and will defer to using only IT-1.19 Antidepressant Medication Management (Standalone)

Process Milestones

- DY2:

- P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-2: Establish baseline rates
  - We will establish our baseline rate. Based on clinician input, we believe about 33% of patients in Baylor Clinics are on an ACE/ARB inhibitor. We do not have any data on how many of those patients received a serum potassium/creatinine or BUN test in the past year.

Outcome Improvement Targets for each year

- DY3:
  - IT-1.2: Annual monitoring for patients on ACE or ARBs (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 2% or 5% depending on baseline established in DY2
- DY4:
  - IT-1.2: Annual monitoring for patients on ACE or ARBs (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 4%, 5% or 10% depending on baseline in DY2
- DY5:
  - IT-1.2: Annual monitoring for patients on ACE or ARBs (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 6%, 9% or 15% depending on the baseline in DY2

Rationale

Approximately 33% of Baylor Clinic patients are on an ACE/ARB medication regimen. Enforcing annual monitoring will improve quality and reconcile the patient's medication to ensure it is still appropriate. In a recent study in the New England Journal of Medicine, compliance to anti-hypertensives was 41%, beta blockers was 49% and statins were 55% after a patient suffered from an AMI.[521] We believe through consistent, proactive management and encouraging patient accountability for taking medications, these rates should increase.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources.

[521] Choudhry, NK, Avorn, J, et. al. Full coverage for preventive medications after myocardial infarction. N Engl J Med 2011; 365:2088-2097

Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.2.5- Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

139485012.3.18	*3.IT-1.2*	*Annual monitoring for patients on persistent medication– angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.2.5– Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*		
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 33% of Baylor Clinic patients take an ACE or ARB inhibitor. We do not know the rate of monitoring for serum potassium/creatinine or BUN.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on an ACE/ARB inhibitor*		

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,493 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $12,493	**Outcome Improvement Target 1** [IT-1.2]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) ACE inhibitors or ARBs (*Non-standalone measure*) Improvement Target: > 2% of patient 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $28,961	**Outcome Improvement Target 2** [IT-1.2]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) ACE inhibitors or ARBs (*Non-standalone measure*) Improvement Target: > 4% of patient 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $46,472	**Outcome Improvement Target 3** [IT-1.2]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) ACE inhibitors or ARBs (*Non-standalone measure*) Improvement Target: > 6% of patient 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $111,129
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $24,985	Year 3 Estimated Outcome Amount: $28,961	Year 4 Estimated Outcome Amount: $46,472	Year 5 Estimated Outcome Amount: $111,129
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $211,547			

Title of Outcome Measure (Improvement Target): IT-1.4 Annual monitoring for patients on persistent medications diuretic *(Non- standalone measure)*

Unique RHP Outcome Identification Number: 139485012.3.19

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Description:
IT-1.4: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non- standalone measure)*

Percentage of members 18 years of age and older who received at least 180 treatment days of a diuretic during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Since we do not have a baseline for patients receiving a serum potassium, serum creatinine or blood urea nitrogen test during the measurement year, we are proposing the following tiers of improvement:

- If 25-50% of patients on a diuretic are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 5% in DY3, 10% in DY4 and 15% in DY5 (all over DY2 baseline)
- If 50-75% of patients on a diuretic are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 5% in DY3, 7% in DY4 and 9% in DY5 (all over DY2 baseline)
- If 75-90% patients on a diuretic are receiving a serum potassium/creatinine or BUN test within one year then our improvements will be 2% in DY3, 4% in DY4 and 6% in DY5 (all over DY2 baseline)
- If 90% or more patients on a diuretic are receiving a serum potassium/creatinine or BUN test within one year then we will not pursue this outcome improvement and will defer to using only IT-1.19 Antidepressant Medication Management (Standalone)

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
        - We will establish our baseline rate. Based on clinician input, we believe about 33% of patients in Baylor Clinics are on a diuretic. We

do not have any data on how many of those patients received a serum potassium/creatinine or BUN test in the past year.

Outcome Improvement Targets for each year

- DY3:
  - IT-1.4: Annual monitoring for patients a diuretic (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 2% or 5% depending on baseline established in DY2
- DY4:
  - IT-1.4: Annual monitoring for patients a diuretic (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 4%, 5% or 10% depending on baseline in DY2
- DY5:
  - IT-1.4: Annual monitoring for patients a diuretic (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum potassium/creatinine or BUN test in the past year to 6%, 9% or 15% depending on the baseline in DY2

Rationale

Approximately 33% of Baylor Clinic patients on a diuretic medication regimen. Enforcing annual monitoring will improve quality and reconcile the patient's medication to ensure it is still appropriate. A study that observed the correlation between a diuretic regimen and cardiovascular related hospitalizations found that patients who take the appropriate dose of diuretics at the appropriate time had a decrease risk of cardiovascular and heart failure related hospitalizations. A large component of the successful adherence was attributed to patient education and engagement in the medication regimen.[522]

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to

[522] Chui, M. A., Deer, M., Bennett, S. J., Tu, W., Oury, S., Brater, D. C. and Murray, M. D. (2003), Association Between Adherence to Diuretic Therapy and Health Care Utilization in Patients with Heart Failure. Pharmacotherapy, 23: 326–332. doi: 10.1592/phco.23.3.326.32112

determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.2.5- Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program - Medication Management and Prescription Assistance Program

139485012.3.19	*3.IT-1.4*	*Annual monitoring for patients on persistent medications diuretic (Non- standalone measure)*		
Baylor University Medical Center				*139485012*
Related Category 1 or 2 Projects:	*139485012.2.5***–** *Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program - Medication Management and Prescription Assistance Program*			
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 33% of Baylor Clinic patients take a diuretic. We do not know the rate of monitoring for serum potassium/creatinine or BUN.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on a diuretic*			
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,493 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $12,493		**Outcome Improvement Target 1** [IT-1.4]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non- standalone measure)* Improvement Target: > 2% of patient 18 years of age and older who received at least 180 treatment days of diuretics during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $28,961	**Outcome Improvement Target 2** [IT-1.4]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non- standalone measure)* Improvement Target: > 4% of patient 18 years of age and older who received at least 180 treatment days of diuretics during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $46,472	**Outcome Improvement Target 3** [IT-1.4]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) diuretic *(Non-standalone measure)* Improvement Target: > 6% of patient 18 years of age and older who received at least 180 treatment days of diuretics during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $111,130
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $24,985		Year 3 Estimated Outcome Amount: $28,961	Year 4 Estimated Outcome Amount: $46,472	Year 5 Estimated Outcome Amount: $111,130
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $211,548				

Title of Outcome Measure (Improvement Target): IT-1.5 Annual monitoring for patients on persistent medications-anticonvulsant *(Non- standalone measure)*

Unique RHP Outcome Identification Number: 139485012.3.20

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Description:

IT-1.5: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non- standalone measure)*

Percentage of members 18 years of age and older who received at least 180 treatment days for an anticonvulsant during the measurement year and had at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year.

Since we do not have a baseline for patients receiving a serum concentration test during the measurement year, we are proposing the following tiers of improvement:

- If 25-50% of patients on an anticonvulsant are receiving a serum concentration test within one year then our improvements will be 5% in DY3, 10% in DY4 and 15% in DY5 (all over DY2 baseline)
- If 50-75% of patients on an anticonvulsant are receiving a serum concentration test within one year then our improvements will be 5% in DY3, 7% in DY4 and 9% in DY5 (all over DY2 baseline)
- If 75-90% of patients on an anticonvulsant are receiving a serum concentration test within one year then our improvements will be 2% in DY3, 4% in DY4 and 6% in DY5 (all over DY2 baseline)
- If 90% of patients on an anticonvulsant are receiving a serum concentration test within one year then we will not pursue this outcome improvement and will defer to using only IT-1.19 Antidepressant Medication Management (Standalone)

Process Milestones

- DY2:
    - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline rates
        - We will establish our baseline rate. Based on clinician input, we believe about 5% of patients in Baylor Clinics are on an

anticonvulsant. We do not have any data on how many of those patients received a serum test in the past year.

Outcome Improvement Targets for each year

- DY3:
  - IT-1.5: Annual monitoring for patients an anticonvulsant (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum concentration test in the past year to 2% or 5% depending on baseline established in DY2
- DY4:
  - IT-1.5: Annual monitoring for patients an anticonvulsant (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum concentration test in the past year to 4%, 5% or 10% depending on baseline in DY2
- DY5:
  - IT-1.5: Annual monitoring for patients an anticonvulsant (Non-Standalone)
    - Our goal is increase the % of patients that have had a serum concentration test in the past year to 6%, 9% or 15% depending on the baseline in DY2

Rationale

Only about 5% of Baylor Clinic patients are on an anticonvulsant medication regimen. This may be because there are no formal behavioral health programs in the Baylor Clinic, it is possible that identification of BH issues is low and utilization of anticonvulsants would increase with an increased emphasis on identifying BH issues. A study in Psychiatric Services found that 50% of patients that were given anticonvulsant prescriptions to treat bipolar disorder were non-adherent.[523] This issue can be resolved by explaining the risks v. benefits for taking an anticonvulsant.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and

[523] Sajattovic, M, et. al. Treatment adherence with lithium and anticonvulsant medications among patients with bipolar disorder. *Psychiatric Services*. 58(6):855-63. 2007.

hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.2.5- Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

139485012.3.20	*3.IT-1.5*	*Annual monitoring for patients on persistent medications-anticonvulsant (Non- standalone measure)*		
Baylor University Medical Center				*139485012*
Related Category 1 or 2 Projects:	*139485012.2.5– Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*			
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 5% of Baylor Clinic patients take an anticonvulsant. We do not know the rate of monitoring for serum concentration testing.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on an anticonvulsant.*			
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,493 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $12,493		**Outcome Improvement Target 1** [IT-1.5]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non-standalone measure)* Improvement Target: > 2% of patients 18 years of age and older who received at least 180 treatment days of anticonvulsants during the measurement year and had at least one serum concentration test in the measurement year. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $28,961	**Outcome Improvement Target 2** [IT-1.5]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non- standalone measure)* Improvement Target: > 4% of patients 18 years of age and older who received at least 180 treatment days of anticonvulsants during the measurement year and had at least one serum concentration test in the measurement year. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $46,472	**Outcome Improvement Target 3** [[IT-1.5]: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) anticonvulsant *(Non- standalone measure)* Improvement Target: > 6% of patient s18 years of age and older who received at least 180 treatment days of anticonvulsants during the measurement year and had at least one serum concentration test in the measurement year. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $111,130
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $24,985		Year 3 Estimated Outcome Amount: $28,961	Year 4 Estimated Outcome Amount: $46,472	Year 5 Estimated Outcome Amount: $111,130
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $211,548				

Title of Outcome Measure (Improvement Target): IT-1.19 Antidepressant Medication Management *(Standalone measure)*

Unique RHP Outcome Identification Number: 139485012.3.21

Performing Provider Name/TPI: Baylor University Medical Center/139485012

Outcome Description:

IT-1.19: Antidepressant Medication Management - NQF 0105237 *(Standalone measure)*

Numerator:
A) Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

B) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).

Denominator: Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year.

***Note** because this project will occur in an ambulatory setting, we will need to modify the denominator to more accurately measure the impact of this outcome. Instead of members discharged from an acute inpatient setting with a mental health diagnosis (as many of these patients may not come to a Baylor Clinic), we propose changing the denominator to all patients at a Baylor Clinic on the Baylor University Medical Center campus with an identified mental health issue and on a psychiatric medication.

We do not have an established baseline of tracking patients who received Acute Phase/Continuation phase treatment with antidepressants. Based on the baseline analysis in DY2, we may have to reevaluate or modify this outcome.

Process Milestones

- DY2:
  - P-1: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline rates
    - We will establish our baseline rate. Based on clinician input, we believe about 20% of patients in Baylor Clinics are on an antidepressant. We do not have any data on how many of those patients received acute/continuous phase treatment.

Outcome Improvement Targets for each year

- DY3:
  - IT-1.19: Antidepressant Medication Management (Standalone)
    - Our goal is increase the % of patients that have are engaged in Effective Acute Phase Treatment by 5%
    - Our goal is to increase the % of patients that have engaged in Effective Continuous Phase Treatment by 3%
- DY4:
  - IT-1.19: Antidepressant Medication Management (Standalone)
    - Our goal is increase the % of patients that have are engaged in Effective Acute Phase Treatment by 10%
    - Our goal is to increase the % of patients that have engaged in Effective Continuous Phase Treatment by 5%
- DY5:
  - IT-1.19: Antidepressant Medication Management (Standalone)
    - Our goal is increase the % of patients that have are engaged in Effective Acute Phase Treatment by 15%
    - Our goal is to increase the % of patients that have engaged in Effective Continuous Phase Treatment by 7%

Rationale

Approximately 20% of Baylor Clinic patients on an antidepressant medication regimen. According to the Community Health Needs Assessment, behavioral health is a major issue in the

region. The top 10 utilizers in the region had BH related issues.[524] While antidepressants are not the solution to this problem, managing depression can have other positive ancillary effects on clinical adherence and avoidance of BH exacerbations. This outcome enforces both short and long term adherence to this drug in order to avoid adverse events for patients. An article in the Journal of Clinical Psychiatry, evidence was found "…to support collaborative care interventions in a primary care setting demonstrated significant improvements in antidepressant drug adherence during the acute and continuous phase of treatment and were associated with clinical benefit, especially in patients suffering from major depression and were prescribed adequate dosages of antidepressant medication.[525]" Our project supports this methodology.

Outcome Measure Valuation

Approach/Methodology: In one of the RHPs that Baylor Health Care System is participating in, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence based resources. Additionally, based on the weighted criteria we used to determine the funding allocation for each Category and 1 and 2 project, the same weight was used to determine the total Category 3 funding. From there, based on the complexity, difficulty of achieving a particular outcome, involvement/resources required, we individually weighed each of the outcomes for a project to determine the value for the milestones and metrics. Outcomes such as diabetes and hypertension improvement were weighted more than outcomes such as patient satisfaction or diabetic foot exams because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have.

Related Category 1 and/or 2 projects

139485012.2.5- Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program

[524] RHP 9 Community Health Needs Assessment

[525] Vergouwen, AC, et. al. Improving adherence to antidepressants: a systematic review of interventions. *J Clin Psychiatry.* 64(12):1415-20. 2003.

139485012.3.21	*3.IT-1.19*	*Antidepressant Medication Management (Non- standalone measure)*	
Baylor University Medical Center			*139485012*
Related Category 1 or 2 Projects:	*139485012.2.5– Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*		
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 20% of Baylor Clinic patients take an anticonvulsant. We do not know the rate of monitoring for serum concentration testing.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on an antidepressant.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,493 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $12,493	**Outcome Improvement Target 1** [IT-1.19]: Antidepressant Medication Management - NQF 0105237 *(Standalone measure)* Improvement Target: • Increase the % of patients that have are engaged in Effective Acute Phase Treatment by 5% • Increase the % of patients that have engaged in Effective Continuous P**h**ase Treatment by 3% Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $28,961	**Outcome Improvement Target 2** [IT-1.19]: Antidepressant Medication Management - NQF 0105237 *(Standalone measure)* Improvement Target: • Increase the % of patients that have are engaged in Effective Acute Phase Treatment by 10% • Increase the % of patients that have engaged in Effective Continuous Phase Treatment by 5% Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $46,472	**Outcome Improvement Target 3** [IT-1.19]: Antidepressant Medication Management - NQF 0105237 *(Standalone measure)* Improvement Target: • Increase the % of patients that have are engaged in Effective Acute Phase Treatment by 15% • Increase the % of patients that have engaged in Effective Continuous Phase Treatment by 7% Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $111,130
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $24,985	Year 3 Estimated Outcome Amount: $28,961	Year 4 Estimated Outcome Amount: $46,472	Year 5 Estimated Outcome Amount: $111,130

139485012.3.21	*3.IT-1.19*	*Antidepressant Medication Management (Non- standalone measure)*		
Baylor University Medical Center				*139485012*
Related Category 1 or 2 Projects:	*139485012.2.5***–** *Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program*			
Starting Point/Baseline:	***Baseline:*** *We do not have a baseline established for this project. We do know that about 20% of Baylor Clinic patients take an anticonvulsant. We do not know the rate of monitoring for serum concentration testing.* ***Target Population:*** *Uninsured and Medicaid patients in the Baylor Clinic on an antidepressant.*			
Year 2 (10/1/2012 – 9/30/2013)		**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):* $211,548				

Title of Outcome Measure (Improvement Target): ED Appropriate Utilization

Unique RHP project identification number: 138910807.3.1

Performing Provider Name/TPI: Children's Medical Center/138910807

Outcome Measure Description

Category 3 – OD-9 Preventive and Primary Care)

- IT-9.2 Reduce pediatric Emergency Department visits

Decrease inappropriate Emergency Department use by expanding access to pediatric primary care by opening additional MyChildren's primary care locations, establishing a primary care and care coordination service for children with complex chronic illness and using telemedicine in school settings to gain access to pediatric primary care and low complexity specialty pediatric services.

Process Milestones

- **DY2:**
  - **Milestone 1 P1:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans.
  - **Milestone 2 P2:** Establish baseline rates
  - **Milestone 3 P3:** Develop and test data systems
- **DY3:**
  - **Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - **Milestone 5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for Each Year:

- **DY4:**
  - **Milestone 6 IT 9.2:** Achieve 5% reduction in Emergency Department use, for patients enrolled in MyChildren's, complex chronic service or receiving care through telemedicine services in the schools for the entire DY4 timeframe compared to DY3 Emergency Department use for the same patient cohort.
- **DY5:**

- **Milestone 7 IT 9.2:** Achieve 10% reduction in Emergency Department use, for patients enrolled in MyChildren's, complex chronic service or receiving care through telemedicine services in the schools for the entire DY4 and DY5 timeframe compared to DY3 Emergency Department use for the same patient cohort.

Rationale

Improving access to primary care by opening new pediatric primary care offices, providing a medical home for children with complex and chronic medical conditions and providing telemedicine services through school settings for primary and low complexity specialty care for children should reduce inappropriate use as well as overall use of Emergency Department services. Process and improvement milestones were selected to support the successful implementation of the project.

Project Valuation

This project was valued using the score for project 1.1 which was valued using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	9	1.80
Population Served / Project Size	25%	8	2.00
Alignment with Community Needs	20%	9	1.80
Cost Avoidance	15%	8	1.20
Sustainability	15%	8	1.20
Partnership Collaboration	5%	8	0.40
	100%		8.40

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact

Moderate Weakness: Lessens impact

Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

References

1. Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. J Am Board Fam Med. 2011 May-Jun;24(3):240-8.

2. Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients.

3. J Paediatr Child Health. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

4. Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A Profile of Nonurgent Emergency Department Use in an Urban Pediatric Hospital. Pediatr Emerg Care. 2012 Sep 26

5. Liberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low Rates of Follow-Up With Primary Care Providers After Pediatric Emergency Department Visits for Respiratory Tract Illnesses. Pediatr Emerg Care. 2012 Sep 26

138910807.3.1	***REFERENCE NUMBER: OD 9.2***	***ED APPROPRIATE UTILIZATION***	
Children's Medical Center of Dallas			*138910807*
Related Category 1 and 2 Projects:	*138910807.1.1*		
Starting Point/ Baseline:	*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)**
Milestone 1 P1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 1 Estimated Incentive Payment *(maximum amount):* $132446 **Milestone 2 P2:** Establish baseline rates **Data source:** Clinical and financial data **Goal: Completed by 9/30/2013** Milestone 2 Estimated Incentive Payment *(maximum amount):* $ $132,447 **Milestone 3 P3:** Develop and test data systems **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 3 Estimated Incentive Payment *(maximum amount):* $ $132,447	**Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data souce:** Administrative data **Goal: Completed by 9/30/2014** Milestone 4 Estimated Incentive Payment *(maximum amount):* $ $230,284 **Milestone 5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders. **Data souce:** Administrative data1 **Goal: Completed by 9/30/2014** Milestone 5 Estimated Incentive Payment *(maximum amount):* $ $230,285	**Milestone 6 IT 9.2:** Achieve 5% reduction in Emergency Department use **Metri :** Documented evidence of performance achieved. **Data Definitions** Denominator: Patients enrolled in MyChildren's practices, in the complex chronic service or receiving telemedicine services through a school setting during the entire DY4 time period. Data source: MyChildren's electronic medical record, Children's electronic health record and health plan record. This patient group defined as Cohort DY4. Baseline Numerator: Number of Children's Medical Center emergency department visits by Cohort DY4 during DY3. Data source: MyChildren's electronic medical record and Children's electronic record. Numerator DY4: Number	**Milestone 7 IT 9.2:** Achieve 10% reduction in Emergency Department use. **Metric :** Documented evidence of performance achieved. **Data Definitions** Numerator DY5: Number of Children's Medical Center emergency department visits by Cohort DY4 still enrolled in MyChildren's practices, complex chronic service or receiving telemedicine services though a school setting during entire DY5. Data source: MyChildren's electronic medical record (to identify Cohort DY4) and Children's electronic record (to identify emergency department visits by Cohort DY4) **Goal: Completed by 9/30/2016** **Milestone 7 Estimated Incentive Payment:** $767,294

138910807.3.1	***REFERENCE NUMBER: OD 9.2***	***ED APPROPRIATE UTILIZATION***	
Children's Medical Center of Dallas			*138910807*
Related Category 1 and 2 Projects:	*138910807.1.1*		
Starting Point/ Baseline:	*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)**
		oChildren's Medical Center emergency department visits by Cohort DY4 during DY4. Data source: MyChildren's electronic medical record (to identify Cohort DY4) and Children's electronic record (to identify emergency department visits by Cohort DY4) **Goal: 5% reduction in utilization** **Completed by 9/30/2015** Milestone 6 IT-9.2 Estimated Incentive Payment *(maximum amount):* $739,051	
Year 2 Estimated Milestone Bundle Amount: $397,340	Year 3 Estimated Milestone Bundle Amount: $460,569	Year 4 Estimated Milestone Bundle Amount: $739,051	Year 5 Estimated Milestone Bundle Amount: $1,767,294
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,364,254			

Title of Outcome Measure (Improvement Target): ED Appropriate Utilization

Unique RHP project identification number: 138910807.3.2

Performing Provider Name/TPI: Children's Medical Center/138910807

Outcome Measure Description

Category 3 – OD-9 Preventive and Primary Care

- IT-9.2 ED Appropriate Utilization

Decrease inappropriate Emergency Department use by expanding access to pediatric primary care by establishing a 24/7 nurse triage line and expanding primary care hours in MyChildren's locations.

Process Milestones

- **DY2:**
  - **Milestone 1 P1:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans.
  - **Milestone 2 P2:** Establish baseline rates
  - **Milestone 3 P3:** Develop and test data systems
- **DY3:**
  - **Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - **Milestone 5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for Each Year:

- **DY4:**
  - **Milestone 6 IT 9.2:** Achieve 5% reduction in Emergency Department use for patients enrolled in MyChildren's for the entire DY4 timeframe compared to DY3 Emergency Department use for the same patient cohort.
- **DY5:**
  - **Milestone 7 IT 9.2:** Achieve 10% reduction in Emergency Department use for patients enrolled in MyChildren's for the entire DY4 and DY5 timeframe compared to DY3 Emergency Department use for the same patient cohort.

Rationale

Improving access to primary care by offering expanded office hours and providing a 24/7 nurse triage telephone service should reduce inappropriate use as well as overall use of Emergency Department services. Studies have demonstrated an improved appropriate use of Emergency Departments services (both decrease in inappropriate use and increase in use when that level of care is warranted) by parents who use a 24 hour nurse telephone triage service prior to seeking care. Process and improvement milestones were selected to support the successful implementation of the project.

Project Valuation

This project was valued using the score for project 1.2 which was valued using the using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	9	1.80
Population Served / Project Size	25%	5	1.25
Alignment with Community Needs	20%	9	1.80
Cost Avoidance	15%	8	1.20
Sustainability	15%	8	1.20
Partnership Collaboration	5%	8	0.40
	100%		7.65

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact

Moderate Weakness: Lessens impact

Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into

adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

References

1. Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. J Am Board Fam Med. 2011 May-Jun;24(3):240-8.

2. Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients.

3. J Paediatr Child Health. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

4. Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A Profile of Nonurgent Emergency Department Use in an Urban Pediatric Hospital. Pediatr Emerg Care. 2012 Sep 26

5. Liberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low Rates of Follow-Up With Primary Care Providers After Pediatric Emergency Department Visits for Respiratory Tract Illnesses. Pediatr Emerg Care. 2012 Sep 26

138910807.3.2	***OD 9.2***	***ED APPROPRIATE USE***	
Children's Medical Center of Dallas			*138910807*
Related Category 1 and 2 Projects:	*138910807.1.2*		
Starting Point/ Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 122,258 **Milestone 2 P2:** Establish baseline rates **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 122,258 **Milestone 3 P3:** Develop and test data systems **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 3 Estimated Incentive Payment *(maximum amount):* $ $ 122,258	**Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Milestone 4 Estimated Incentive Payment *(maximum amount):* $ 212,569 **Milestone 5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders. **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Milestone 5 Estimated Incentive Payment *(maximum amount):* $ 212,570	**Milestone 6 IT 9.2:** Achieve 5% reduction in Emergency Department use **Data Definitions** Denominator: Patients enrolled in MyChildren's practices, during the entire DY4 time period. Data source: MyChildren's electronic medical record, Children's electronic health record and health plan record. This patient group defined as Cohort DY4. Baseline Numerator: Number of Children's Medical Center emergency department visits by Cohort DY4 during DY3. Data source: MyChildren's electronic medical record and Children's electronic record. Numerator DY4: Number of Children's Medical Center emergency department visits by Cohort DY4 during DY4. Data source: MyChildren's electronic medical record (to identify Cohort DY4) and Children's electronic record (to identify emergency department visits by Cohort DY4)	**Milestone 7 IT 9.2:** Achieve 10% reduction in Emergency Department use, where "Y" will be determined in Year 2 based on baseline data. **Metric :** Documented evidence of performance achieved. Numerator DY5: Number of Children's Medical Center emergency department visits by Cohort DY4 still enrolled in MyChildren's practices, complex chronic service or receiving telemedicine services though a school setting during entire DY5. Data source: MyChildren's electronic medical record (to identify Cohort DY4) and Children's electronic record (to identify emergency department visits by Cohort DY4) **Goal: Completed by 9/30/2016** Milestone 7 IT 9.2 Estimated Incentive Payment *(maximum amount):* $ 1,631,346

138910807.3.2	***OD 9.2***	***ED APPROPRIATE USE***	
Children's Medical Center of Dallas			*138910807*
Related Category 1 and 2 Projects:	*138910807.1.2*		
Starting Point/ Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Metric: Documented evidence of performance achieved. **Goal: Completed by 9/30/2015** **Data source:** Administrative data Milestone 6 IT 9.2 Estimated Incentive Payment *(maximum amount):* $682,199	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $366,774	Year 3 Estimated Milestone Bundle Amount: $425,139	Year 4 Estimated Milestone Bundle Amount: $682,199	Year 5 Estimated Milestone Bundle Amount: $1,631,346
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,105,458			

Title of Outcome Measure (Improvement Target): Other Admission Rate**:** Pediatric Asthma Inpatient Admission Reduction (Provider Defined Outcome)

Unique RHP project identification number: 138910807.3.3

Performing Provider Name/TPI: Children's Medical Center/138910807

Outcome Measure Description

Category 3 – OD-1: Primary Care and Chronic Disease Managment
IT 2.13 Other Admission Rates: Pediatric Quality Indicator PDI #14 Asthma Admission Rate (Standalone measure).

This is a provider-defined measure. This measure is based on IT 2-12 Prevention Quality Indicator (PQI) Composite Measures for Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions which are adult-based measures. The Pediatric Quality Indicator PDI #14 will be used for the data definition for the numerator in the outcome measure. PDI #14 was selected because asthma management will be a major component of the disease management program. Past history with Children's limited implementation of an asthma management program demonstrated reduced hospital admissions for asthma in the patients enrolled in the program.

Process Milestones

- **DY2:**
  - Milestone **1 P1:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans.
  - Milestone **2 P2:** Establish baseline rates
  - Milestone **3 P3:** Develop and test data systems
- **DY3:**
  - Milestone **4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - Milestone **5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for Each Year

- **DY4:**
  - Milestone **6 IT 2.13:** Achieve 5% reduction in Asthma Admission in MyChidren's patients enrolled in disease management services for a continuous 12 month period compared with number of admissions in the 12 months prior to enrollment in disease management.

- **DY5:**
    - Milestone 7 **IT 2.13:** Achieve 10% reduction in Asthma Admission in MyChidren's patients enrolled in disease management services for a continuous 24 month period compared with number of admissions in the 12 months prior to enrollment in disease management.

Rationale

This measure is based on IT 2-12 Prevention Quality Indicator (PQI) Composite Measures for Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions which are adult-based measures. The Pediatric Quality Indicator PDI #14 will be used for the data definition for the numerator in the outcome measure. PDI #14 was selected because asthma management will be a major component of the disease management program. Past history with Children's limited implementation of an asthma management program demonstrated reduced hospital admissions in the patients enrolled in the program. Process and improvement milestones were selected to support the successful implementation of the project.

Project Valuation

This project was valued using the score for Project 1.3 which was based on the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	7	1.40
Population Served / Project Size	25%	6	1.50
Alignment with Community Needs	20%	9	1.80
Cost Avoidance	15%	6	0.90
Sustainability	15%	8	1.20
Partnership Collaboration	5%	9	0.45
	100%		7.25

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact
Moderate Weakness: Lessens impact
Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

References

1. Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. J Am Board Fam Med. 2011 May-Jun;24(3):240-8.

2. Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients.

3. J Paediatr Child Health. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

4. Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A Profile of Nonurgent Emergency Department Use in an Urban Pediatric Hospital. Pediatr Emerg Care. 2012 Sep 26

5. Liberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low Rates of Follow-Up With Primary Care Providers After Pediatric Emergency Department Visits for Respiratory Tract Illnesses. Pediatr Emerg Care. 2012 Sep 26

138910807.3.3	***REFERENCE NUMBER:*** ***OD 1. IT-2.13***	IT 2.13 Other Admission Rates: Pediatric Quality Indicator PDI #14 Asthma Admission Rate (Standalone measure).	
Children's Medical Center of Dallas			*138910807*
Related Category 1 and 2 Projects:	*138910807.1.3*		
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)**
Milestone 1: P1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Estimated Incentive Payment *(maximum amount):* $ 122,258 **Milestone 2 P2:** Establish baseline rates **Goal: Completed by 9/30/2013** **Data Source:** Administrative data Milestone 1 Estimated Incentive Payment *(maximum amount):* $122,258 **Milestone 3 P3:** Develop and test data systems **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Estimated Incentive Payment *(maximum amount):* $ 122,258	**Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Estimated Incentive Payment *(maximum amount):* $212,569 **Milestone 5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders. **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Estimated Incentive Payment *(maximum amount):* $ 212,570	**Milestone 6 IT-9.3:** Achieve 5% reduction in Asthma Admission in MyChidren's patients enrolled in disease management services for a continuous 12 month period compared with number of admissions in the 12 months prior to enrollment in disease management. **Data definition:** Pediatric Quality Indicator (PDI) #14 Asthma admissions. Denominator: Patients enrolled in disease management program for a continuous 12 month period. Baseline numerator: Number of asthma admissions by patients in above described denominator in the 12 month period prior to enrollment in the disease management program. DY4 numerator number of asthma admissions patients enrolled in disease management for a continuous 12 month period. **Metric 6:** Documented evidence of performance achieved. **Goal: Completed by 9/30/2015** **Data source:** Administrative data	**Milestone 7 IT-9.3:** Achieve 10% reduction in Asthma Admission in MyChidren's patients enrolled in disease management services for a continuous 24 month period compared with number of admissions in the 12 months prior to enrollment in disease management. **Data definition:** Pediatric Quality Indicator (PDI) #14 Asthma admissions. Denominator: Patients enrolled in disease management program for a continuous 24 month period. Baseline numerator: Number of asthma admissions by patients in above described denominator in the 12 month period prior to enrollment in the disease management program. DY4 numerator number of asthma admissions patients enrolled in disease management for a continuous 12 month period . **Metric 7:** Documented evidence of performance achieved. **Goal: Completed by 9/30/2016** **Data source:** Administrative data Milestone 7 IT-9.3 Estimated Incentive Payment *(maximum amount):* $1,631,346

138910807.3.3	***REFERENCE NUMBER:*** ***OD 1. IT-2.13***	IT 2.13 Other Admission Rates: Pediatric Quality Indicator PDI #14 Asthma Admission Rate (Standalone measure).	
Children's Medical Center of Dallas			*138910807*
Related Category 1 and 2 Projects:	*138910807.1.3*		
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)**
		Milestone 6 IT-9.3 Estimated Incentive Payment *(maximum amount):* $ 682,199	
Year 2 Estimated Milestone Bundle Amount: $366,774	Year 3 Estimated Milestone Bundle Amount: $ 425,139	Year 4 Estimated Milestone Bundle Amount: $682,199	Year 5 Estimated Milestone Bundle Amount: $1,631,346
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,105,458			

Title of Outcome Measure (Improvement Target): Follow-up after Hospitalization for Mental Illness

Unique RHP project identification number: 138910807.3.4

Performing Provider Name/TPI: Children's Medical Center/138910807

Outcome Measure Description

OD 1: Primary and Preventive Care and Chronic Disease Management
IT 1-20 Other Outcome Improvement Target: Follow-up visits after new anti-depressant medication prescription. This is a provider-defined outcome measure.

This improvement target was selected to support the appropriate management of pediatric patients when a new antidepressant is started based on guidelines by the FDA. It is important to have frequent contact with pediatric patients during initiation of an antidepressant due to potential for worsening of symptoms and increased suicidal ideations.

Process Milestones:

- **DY2:**
  - **Milestone 1 P1:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans.
  - **Milestone 2 P2:** Establish baseline rates
  - **Milestone 3 P3:** Develop and test data systems
- **DY3:**
  - **Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - **Milestone 5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for Each Year

- **DY4:**
  - **Milestone 6 IT 1.20:** 25% of patients on a new antidepressant prescribed by the MyChildren's psychiatrist receive 4 follow-up visits in the four months after antidepressant initiation.
- **DY5:**

- **Milestone 7 IT 1.20: 30**% of patients on a new antidepressant prescribed by the MyChildren's psychiatrist receive 4 follow-up visits in the four months after antidepressant initiation.

Rationale

Expand pediatric behavioral health capacity in CMC primary care settings to align and coordinate care for behavioral and medical illnesses in an attempt to improve patient/family self-management and reduce unnecessary exacerbation of chronic illnesses. Collaborate with Timberlawn Services for coordination of care between medical services and behavioral health services. This improvement target was selected to support the appropriate management of pediatric patients when a new antidepressant is started based on guidelines by the FDA. It is important to have frequent contact with pediatric patients during initiation of an antidepressant due to potential for worsening of symptoms and increased suicidal ideations. Process and improvement milestones were selected to support the successful implementation of the project.

Project Valuation

This project was valued using the value of Project 1.4 which was developed using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	7	1.40
Population Served / Project Size	25%	7	1.75
Alignment with Community Needs	20%	9	1.80
Cost Avoidance	15%	6	0.90
Sustainability	15%	8	1.20
Partnership Collaboration	5%	9	0.45
	100%		7.50

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact
Moderate Weakness: Lessens impact
Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

References

1. James P. Smith, Gillian C. Smith Long-term Economic Costs of Psychological Problems During Childhood *Social Science & Medicine*, v. 71, no. 1, July 2010, p. 110-115.

2. Aalsma MC, Blythe MJ, Tong Y, Harezlak J, Rosenman MB. Insurance Status of Urban Detained Adolescents. *Journal of Correct Health Care.* 2012 Aug 23. [Epub ahead of print]

3. Dumont IP, Olson AL, Primary care, depression, and anxiety: exploring somatic and emotional predictors of mental health status in adolescents. *J Am Board Fam Med* 2012 May-Jun;25(3):291-9.

4. Jacob MK, Larson JC, Craighead WE Establishing a Telepsychiatry Consultation Practice in Rural Georgia for Primary Care Physicians: A Feasibility Report. *Clin Pediatr (Phila).* 2012 Apr 20.

138910807.3.4	*REFERENCE NUMBER OD1- IT-1.20*	***OTHER OUTCOME IMPROVEMENT TARGET "FOLLOW-UP AFTER NEW ANTIDEPRESSANT PRESCRIPTION"***	
Children's Medical Center of Dallas		*138910807*	
Related Category 1 and 2 Projects:	*138910807.1.4*		
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)**
Milestone 1 P1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 122,258 **Milestone 2 P2:** Establish baseline rates **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 122,258 **Milestone 3 P3:** Develop and test data systems **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 3 Estimated Incentive Payment *(maximum amount):* $ $ 122,257	**Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Milestone 4 Estimated Incentive Payment *(maximum amount):* $ 212,569 **Milestone 5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders. **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Milestone 5 Estimated Incentive Payment *(maximum amount):* $ 212,569	**Milestone 6 IT 1.20** MyChildren's patients who receive a new prescription for antidepressants will receive 4 follow-up visits in the 4 months post implementation of the antidepressant. Numerator: Number of pediatric patients enrolled in MyChildren's during the entire DY who receive a new prescription for antidepressant who receive 4 visits in 4 months after initial prescription. Denominator: Number of pediatric patients enrolled in MyChildren's during the entire DY who receive a new prescription for antidepressant during that DY. Data source: Electronic medical record d. Rationale/Evidence: This improvement target was selected to support the appropriate management of pediatric patients when a new antidepressant is started based on guidelines by the FDA. It is important to have frequent contact with pediatric patients during initiation of an antidepressant due to potential for worsening of symptoms	**Milestone 7 IT 1.20:** MyChildren's patients who receive a new prescription for antidepressants will receive 4 follow-up visits in the 4 months post implementation of the antidepressant. Numerator: Number of pediatric patients enrolled in MyChildren's during the entire DY who receive a new prescription for antidepressant who receive 4 visits in 4 months after initial prescription. Denominator: Number of pediatric patients enrolled in MyChildren's during the entire DY who receive a new prescription for antidepressant during that DY. Data source: Electronic medical record d. Rationale/Evidence: This improvement target was selected to support the appropriate management of pediatric patients when a new antidepressant is started based on guidelines by the FDA. It is important to have frequent contact with pediatric patients during initiation of an antidepressant due to potential for worsening of symptoms and increased

138910807.3.4	*REFERENCE NUMBER OD1- IT-1.20*	***OTHER OUTCOME IMPROVEMENT TARGET "FOLLOW-UP AFTER NEW ANTIDEPRESSANT PRESCRIPTION"***	
Children's Medical Center of Dallas		*138910807*	
Related Category 1 and 2 Projects:	*138910807.1.4*		
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)**
		and increased suicidal ideations. **Metric 6:** Documented evidence of performance achieved. **Goal:** Goal: DY 4: 25% of patients Milestone 6: Estimated Incentive Payment *(maximum amount):* $682,199	suicidal ideations. **Metric 7:** Documented evidence of performance achieved. **Goal:** Goal: DY 5: 30% of patients Milestone 7 Estimated Incentive Payment *(maximum amount):* $ 1,631,345
Year 2 Estimated Milestone Bundle Amount: $366,773	Year 3 Estimated Milestone Bundle Amount: $425,138	Year 4 Estimated Milestone Bundle Amount: $682,199	Year 5 Estimated Milestone Bundle Amount: $1,631,345
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,105,455			

Title of Outcome Measure (Improvement Target): ED Appropriate Utilization

Unique RHP outcome identification number: 138910807.3.5

Performing Provider Name/TPI: Children's Medical Center/138910807

Outcome Measure Description

OD: 9: preventive and Primary Care
IT 9.2: ED Appropriate Utilization

Decrease inappropriate Emergency Department use by transforming MyChildren's primary care offices into NCQA certified medical homes.

Process Milestones

- **DY2:**
  - **Milestone 1 P1:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans.
  - **Milestone 2 P2:** Establish baseline rates
  - **Milestone 3 P3:** Develop and test data systems
- **DY3:**
  - **Milestone 4 P4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities**
  - **Milestone 5 P5: Disseminate findings, including lessons learned and best practices to stakeholders**.

Outcome Improvement Targets for each year

- **DY4:**
  - **Milestone 6 IT 9.2:** Achieve 5% reduction in Emergency Department use for patients enrolled in MyChildren's primary care settings with NCQA-designated medical home certification during the entire DY4 timeframe compared to baseline emergency department use by the same patient population in the 12 months prior to initiation of medical home designation process.
- **DY5:**
  - **Milestone 7 IT 9.2:** Achieve 10% reduction in Emergency Department use for patients enrolled in MyChildren's primary care settings with NCQA-designated medical home certification during the entire DY4 timeframe compared to baseline

emergency department use by the same patient population in the 12 months prior to initiation of medical home designation process.

Rationale

Improving access to primary care by opening new pediatric primary care offices, providing a medical home for children with complex and chronic medical conditions and expanding hours for urgent care should reduce inappropriate use as well as overall use of Emergency Department services. Process and improvement milestones were selected to support the successful implementation of the project.

Outcome Measure Valuation

This project was valued using the score for project 2.1 which was valued using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	9	1.80
Population Served / Project Size	25%	8	2.00
Alignment with Community Needs	20%	9	1.80
Cost Avoidance	15%	8	1.20
Sustainability	15%	9	1.35
Partnership Collaboration	5%	7	0.35
	100%		8.50

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact

Moderate Weakness: Lessens impact

Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

References

1. Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. J Am Board Fam Med. 2011 May-Jun;24(3):240-8.

2. Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients. J Paediatr Child Health. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

3. Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A Profile of Nonurgent Emergency Department Use in an Urban Pediatric Hospital. Pediatr Emerg Care. 2012 Sep 26

4. Liberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low Rates of Follow-Up With Primary Care Providers After Pediatric Emergency Department Visits for Respiratory Tract Illnesses. Pediatr Emerg Care. 2012 Sep 26

138910807.3.5	***REFERENCE NUMBER: 3.IT-9.2***	***REDUCE PEDIATRIC EMERGENCY DEPARTMENT VISITS***	
Children's Medical Center of Dallas			*138910807*
Related Category 1 and 2 Projects:	*138910807.2.1*		
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)**
Milestone 1 P1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 152,822 **Milestone 2 P2:** Establish baseline rates **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 152,822 **Milestone P3:** Develop and test data systems **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 1 Estimated Incentive Payment *(maximum amount):* $152,823	**Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Milestone 2 Estimated Incentive Payment *(maximum amount):* $ $ 265,711 **Milestone P5:** Disseminate findings, including lessons learned and best practices to stakeholders. **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 265,712	**Milestone 6 IT 9.2:** Achieve 5% reduction in Emergency Department use for patients enrolled in MyChildren's primary care settings with NCQA-designated medical home certification during the entire DY4 timeframe compared to baseline emergency department use by the same patient population in the 12 months prior to initiation of medical home designation process. **Metric 6:** Documented evidence of performance achieved. **Goal: Completed by 9/30/2015** **Data source:** Administrative data Milestone 6 IT 9.2 Estimated Incentive Payment *(maximum amount):* $ 852,749	**Milestone 7 IT 9.2:** Achieve 10% reduction in Emergency Department use for patients enrolled in MyChildren's primary care settings with NCQA-designated medical home certification during the entire DY4 timeframe compared to baseline emergency department use by the same patient population in the 12 months prior to initiation of medical home designation process. **Metric 7:** Documented evidence of performance achieved. **Goal: Completed by 9/30/2016** **Data source:** Administrative data Milestone 7 IT 9.2 Estimated Incentive Payment *(maximum amount):* $ 2,039,182
Year 2 Estimated Milestone Bundle Amount: $ 458,467	Year 3 Estimated Milestone Bundle Amount: $ 531,423	Year 4 Estimated Milestone Bundle Amount: $ 852,749	Year 5 Estimated Milestone Bundle Amount: $2,039,182
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $3,881,821			

Title of Outcome Measure (Improvement Target): ED Appropriate Utilization – Pediatric/ Young Asthma Emergency Department Visits

Unique RHP outcome identification number: 138910807.3.6

Performing Provider Name/TPI: Children's Medical Center/138910807

Outcome Measure Description

OD9: Primary and Preventive Care
IT 9.3 Pediatric/Young Adult Asthma Emergency Department Visits

Decrease Pediatric and Young Adult Asthma Emergency Department Visits by implementing an evidenced-based health promotions program in the community focusing on asthma.

Process Milestones

- **DY2:**
  - **Milestone 1 P1:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans.
  - **Milestone 2 P2:** Establish baseline rates
  - **Milestone 3 P3:** Develop and test data systems

- **DY3:**
  - **Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - **Milestone 5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for each year:

- **DY4:**
  - **Milestone 6 IT 9.3** Achieve 10%" reduction in Pediatric Asthma Emergency Department Visits, compared with Year 2 baseline data.

- **DY5:**
  - **Milestone 6 IT 9.3** Achieve 10%" reduction in Pediatric Asthma Emergency Department Visits, compared with Year 2 baseline data.

Rationale

By coordinating community-based efforts for reducing the incidence of asthma and increasing asthma management skills as well as promoting overall health and healthy lifestyles, the use of the Emergency Department for treatment of pediatric and young adult asthma should decline. Process and improvement milestones were selected to support the successful implementation of the project.

Outcome Measure Valuation

This project was valued using the score for project 2.2 which was valued using the using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	9	1.80
Population Served / Project Size	25%	9	2.25
Alignment with Community Needs	20%	9	1.80
Cost Avoidance	15%	7	1.05
Sustainability	15%	7	1.05
Partnership Collaboration	5%	9	0.45
	100%		8.40

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact

Moderate Weakness: Lessens impact

Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

References

1. Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. J Am Board Fam Med. 2011 May-Jun;24(3):240-8.

2. Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients.

3. J Paediatr Child Health. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

4. Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A Profile of Nonurgent Emergency Department Use in an Urban Pediatric Hospital. Pediatr Emerg Care. 2012 Sep 26

5. Liberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low Rates of Follow-Up With Primary Care Providers After Pediatric Emergency Department Visits for Respiratory Tract Illnesses. Pediatr Emerg Care. 2012 Sep 26

138910807.3.6	***IT- 3.9.3***	***REDUCE PEDIATRIC / YOUNG ADULT ASTHMA EMERGENCY DEPARTMENT VISITS***	
Children's Medical Center of Dallas			*138910807*
Related Category 1 and 2 Projects:	*138910807.2.2*		
Starting Point/ Baseline:	*Baseline will 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)**
Milestone 1 P1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 132,446 **Milestone 2 P2:** Establish baseline rates **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 132,446 **Milestone 3 P3:** Develop and test data systems **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 3 Estimated Incentive Payment *(maximum amount):* $ $ 132,446	**Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Milestone 4 Estimated Incentive Payment *(maximum amount):* $ 230,283 **Milestone 5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders. **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Milestone 5 Estimated Incentive Payment *(maximum amount):* $ 230,283	**Milestone 6 IT 9.3:** Achieve 10% reduction in Pediatric and Young Adult Asthma Visits in the Emergency Department compared to baseline data. Numerator: Pediatric Asthma visits in the Emergency Department for pediatric and young adults in Dallas County. Denominator: Estimated # of children in Dallas County with asthma (10% incidence rate). **Metric 6:** Documented evidence of performance achieved. **Goal: Completed by 9/30/2015** **Data source:** Administrative data Milestone 6 Estimated Incentive Payment *(maximum amount):* $ 739,049	**Milestone 7: IT 9.3:** Achieve 20% reduction in Pediatric and Young Adult Asthma Visits in the Emergency Department compared to baseline data. Numerator: Pediatric Asthma visits in the Emergency Department for pediatric and young adults in Dallas County. Denominator: Estimated # of children in Dallas County with asthma (10% incidence rate). . **Metric 7:** Documented evidence of performance achieved. **Goal: Completed by 9/30/2016** **Data source:** Administrative data Milestone 7 Estimated Incentive Payment *(maximum amount):* $ 1,767,291
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 397,338	Year 3 Estimated Milestone Bundle Amount: $ 460,566	Year 4 Estimated Milestone Bundle Amount: $ 739,049	Year 5 Estimated Milestone Bundle Amount: $ 1,767,291

138910807.3.6	***IT- 3.9.3***	***REDUCE PEDIATRIC / YOUNG ADULT ASTHMA EMERGENCY DEPARTMENT VISITS***	
Children's Medical Center of Dallas			*138910807*
Related Category 1 and 2 Projects:	*138910807.2.2*		
Starting Point/ Baseline:	*Baseline will 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 milestone bundle amounts over Years 2-5):* $3,364,244			

Title of Outcome Measure (Improvement Target): ED Appropriate Utilization

Unique RHP outcome identification number: 138910807.3.7

Performing Provider Name/TPI: Children's Medical Center/138910807

Outcome Measure Description

OD9: Primary and Preventive Care
IT 9.2 ED Appropriate Utilization

Decrease inappropriate Emergency Department use by expanding use of patient navigators and care coordinators for pediatric patients and their families who habitually use the emergency department for primary care and for patients and families who need assistance in navigating the health care system.

Process Milestones

- **DY2:**
  - **Milestone 1 P1:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans.
  - **Milestone 2 P2:** Establish baseline rates
  - **Milestone 3 P3:** Develop and test data systems

- **DY3:**
  - **Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - **Milestone 5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for each year

- **DY4:**
  - **Milestone 6 IT-9.2:** Achieve 5% reduction in Emergency Department use," based on baseline data for this patient population.

- **DY5:**
  - **Milestone 7 IT-9.2:** Achieve 10% reduction in Emergency Department use," based on baseline data for this patient population.

Rationale

Developing patient/family navigation for patients and families who habitually use the Emergency Department for primary care and for patients and families who need assistance in navigating the healthcare system should reduce inappropriate use as well as overall use of Emergency Department services. Process and improvement milestones were selected to support the successful implementation of the project.

Outcome Measure Valuation

This project was valued using the score for Project 2.3 which was based on the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	9	1.80
Population Served / Project Size	25%	8	2.00
Alignment with Community Needs	20%	8	1.60
Cost Avoidance	15%	8	1.20
Sustainability	15%	9	1.35
Partnership Collaboration	5%	7	0.35
	100%		8.30

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact

Moderate Weakness: Lessens impact

Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

References

1. Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. J Am Board Fam Med. 2011 May-Jun;24(3):240-8.

2. Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients.

3. J Paediatr Child Health. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

4. Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A Profile of Nonurgent Emergency Department Use in an Urban Pediatric Hospital. Pediatr Emerg Care. 2012 Sep 26

5. Liberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low Rates of Follow-Up With Primary Care Providers After Pediatric Emergency Department Visits for Respiratory Tract Illnesses. Pediatr Emerg Care. 2012 Sep 26

138910807.3.7	***3.IT-9.2***	***EMERGENCY DEPARTMENT UTILIZATION***	
Children's Medical Center of Dallas			*138910807*
Related Category 1 and 2 Projects:	*138910807.2.3*		
Starting Point/ Baseline:	*Baseline will 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)**
Milestone 1 P1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 132,446 **Milestone 2 P2:** Establish baseline rates **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 132,446 **Milestone 3 P3:** Develop and test data systems **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 132,446	**Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 230,283 **Milestone 5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders. **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 230,283	**Milestone 6: IT-9.2:** Achieve 5% reduction in Emergency Department for the patient population receiving navigation services compared with baseline data. Data definition: number of Emergency Department visits by patient population receiving navigation services after navigation services were initiated. **Metric 6:** Documented evidence of performance achieved. **Goal: Completed by 9/30/2015** **Data source:** Administrative data Milestone 6: Estimated Incentive Payment *(maximum amount):* $ 739,049	**Milestone 7: IT-9.2:** Achieve 10% reduction in Emergency Department for the patient population receiving navigation services compared with baseline data. Data definition: number of Emergency Department visits by patient population receiving navigation services after navigation services were initiated. **Metric 7:** Documented evidence of performance achieved. **Goal: Completed by 9/30/2016** **Data source:** Administrative data Milestone 7: Estimated Incentive Payment *(maximum amount):* $ 1,767,291
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 397,338	Year 3 Estimated Milestone Bundle Amount: $ 460,566	Year 4 Estimated Milestone Bundle Amount: $739,049	Year 5 Estimated Milestone Bundle Amount: $1,767,291

138910807.3.7	***3.IT-9.2***	***EMERGENCY DEPARTMENT UTILIZATION***	
Children's Medical Center of Dallas			*138910807*
Related Category 1 and 2 Projects:	*138910807.2.3*		
Starting Point/ Baseline:	*Baseline will 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 milestone bundle amounts over Years 2-5)**:*** $ 3,364,244			

Title of Outcome Measure (Improvement Target): ED Appropriate Utilization

Unique RHP outcome identification number: 138910807.3.8
Performing Provider Name/TPI: Children's Medical Center/138910807

Outcome Measure Description

OD9: Primary and Preventive Care
IT 9.2 ED Appropriate Utilization

Decrease inappropriate Emergency Department use by implementing a transition program to provide continuous care during transition from pediatric providers to adult providers for selected cohorts of patients.

Process Milestones

- **DY2:**
  - **Milestone 1 P1:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans.
  - **Milestone 2 P2:** Establish baseline rates
  - **Milestone 3 P3:** Develop and test data systems
- **DY3:**
  - **Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - **Milestone 5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for Each Year:

- **DY4:**
  - **Milestone 6 IT 9.2:** Achieve 5% reduction in Children's Emergency Department use for young adults who have completed the transition program and have "graduated" into adult care. Improvement will be based on comparison with baseline data established in DY2.
- **DY5:**
  - **Milestone 7 IT 9.2:** Achieve 10% reduction in Children's Emergency Department use for young adults who have completed the transition program and have "graduated" into adult care. Improvement will be based on comparison with baseline data established in DY2.

Rationale

Implementing/expanding care transitions program assisting in transitioning patients who are aging out of pediatric care and securing them services by adult providers should reduce inappropriate use as well as overall use of Emergency Department services. Process and improvement milestones were selected to support the successful implementation of the project.

Outcome Measure Valuation

This project was valued using the score for project 2.4 which was valued using the RHP 9 Scoring Criteria Guidance with a 1 to 9 scoring range and a weighted score based on:

	Weight	Score (1-9)	Weighted Score
Transformational Impact	20%	7	1.40
Population Served / Project Size	25%	5	1.25
Alignment with Community Needs	20%	6	1.20
Cost Avoidance	15%	6	0.90
Sustainability	15%	8	1.20
Partnership Collaboration	5%	9	0.45
	100%		6.40

Scoring Guidance:

Scoring Grid		General Scoring Frame
High	9	Exceptionally strong with essentially no weaknesses
	8	Extremely strong with negligible weaknesses
	7	Very strong with only minor weaknesses
Medium	6	Strong but with numerous minor weaknesses
	5	Strong but with at least one moderate weakness
	4	Some strengths but also some moderate weaknesses
Low	3	Some strengths but with at least one major weakness
	2	A few strengths and a few major weaknesses
	1	Very few strengths and numerous major weaknesses

Minor Weakness: Easily addressable weakness, does not substantially lessen impact

Moderate Weakness: Lessens impact

Major Weakness: Severely limits impact

Each point on the scale was given a value of $1,609,640 based on expected savings, improved outcomes and improved satisfaction with the healthcare system of the life of the project and beyond the life of the project as all patients are pediatric with expected impact to continue into adulthood. The overall project value was then divided between Category 1, 2 and 3 based on HHSC guidelines with Category 4 being allotted the maximum 15% in later years by reporting on the optional Domain 6.

References

1. Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. J Am Board Fam Med. 2011 May-Jun;24(3):240-8.

2. Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients.

3. J Paediatr Child Health. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

4. Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A Profile of Nonurgent Emergency Department Use in an Urban Pediatric Hospital. Pediatr Emerg Care. 2012 Sep 26

5. Liberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low Rates of Follow-Up With Primary Care Providers After Pediatric Emergency Department Visits for Respiratory Tract Illnesses. Pediatr Emerg Care. 2012 Sep 26

138910807.3.8	***OD 3.9.2***	***EMERGENCY DEPARTMENT UTILIZATION***	
Children's Medical Center of Dallas			*138910807*
Related Category 1 and 2 Projects:	*138910807.2.4*		
Starting Point/ Baseline:	*Baseline will be established 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)**
Milestone 1 P1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 101,261 **Milestone 2 P2:** Establish baseline rates **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 101,262 **Milestone 3 P3:** Develop and test data systems **Data Source:** Administrative data **Goal: Completed by 9/30/2013** Milestone 3 Estimated Incentive Payment *(maximum amount):* $ $ 101,262	**Milestone 4 P4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Milestone 4 Estimated Incentive Payment *(maximum amount):* $176,064 **Milestone 5 P5:** Disseminate findings, including lessons learned and best practices to stakeholders. **Data Source:** Administrative data **Goal: Completed by 9/30/2014** Milestone 5 Estimated Incentive Payment *(maximum amount):* $ 176,063	**Milestone 6 IT-9.2:** Achieve 5% reduction in Children's Emergency Department use for young adults who have completed the transition program and have "graduated" into adult care. Improvement will be based on comparison with baseline data established in DY2. **Metric 6:** Documented evidence of performance achieved. **Goal: Completed by 9/30/2015** **Data source:** Administrative data Milestone 6: Estimated Incentive Payment *(maximum amount):* $ 565,041	**Milestone 6 IT-9.2:** Achieve 5% reduction in Children's Emergency Department use for young adults who have completed the transition program and have "graduated" into adult care. Improvement will be based on comparison with baseline data established in DY2. **Metric 7:** Documented evidence of performance achieved. **Goal: Completed by 9/30/2016** **Data source:** Administrative data Milestone 7: Estimated Incentive Payment *(maximum amount):* $ 1,351,185
Year 2 Estimated Milestone Bundle Amount :$303,785	Year 3 Estimated Milestone Bundle Amount: $352,127	Year 4 Estimated Milestone Bundle Amount: $565,041	Year 5 Estimated Milestone Bundle Amount: $1,351,185
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $2,572,138			

Title of Outcome Measurement (Improvement Target): IT-9.1 Decrease in Mental Health Admissions and Readmissions to Criminal Justice Settings

Unique RHP Outcome identification number: 121758005.3.1

Performing Provider Name/TPI: Dallas County/121758005

Outcome Measure Description

IT-9.1: Decrease in Mental Health Admissions and Readmissions to Criminal Justice Settings
Decreasing the number of mental health admissions and re-admissions to the Dallas County Jail is directly related to the associated Category 1 project and captures the success of the Category 1 project in reducing the number of persons in behavioral health (including substance abuse) crisis in the Dallas County Jail. In Dallas County, the proportion of persons admitted to the Dallas County Jail with a history of receiving behavioral health services through the NorthSTAR system has increase each year since 2007.

Process Milestones

DY2: P-1, Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
P-3, Develop and Test Data Systems

DY3: P-2, Establish Baseline Rates
P-4, Conduct PDSA cycles
P-5, Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets

DY4: IT 9.1 – Reduce Mental Health Admissions and Re-Admissions to the Dallas County Jail by 2% from baseline
DY5: IT 9.2 – Reduce Mental Health Admissions and Re-Admissions to the Dallas County Jail by 3% from baseline

Rationale

The core goal of the Category 1 project is to increase access to community-based services for persons in behavioral health crisis, with the associated decrease in the number of persons with behavioral health treatment needs admitted or re-admitted to the Dallas County Jail. The initial planning that will occur in DY 2 and DY 3 will inform and determine the baseline for the actual outcome targets for DY 4 and 5.

Outcome Measure Valuation

The outcome measure valuation is based upon reducing the number of persons with behavioral health treatment needs who are admitted or re-admitted to the Dallas County Jail. There is a specific cost to Dallas County for each day someone is in jail and costs to Parkland Hospital for providing the behavioral health care while those individuals are in the jail. The planning work of DY 2 and 3 will inform that expected reduction in behavioral health admissions and re-admissions to the Dallas County Jail (and the associated cost savings) during DY 4 and 5.

Related Category 1 or 2 Project

- 121758005.1.1: Develop behavioral health crisis stabilization services

121758005.3.1	*3.IT-9.1*	*Decrease in Mental Health Admissions and Readmissions to Criminal Justice Settings*	
Dallas County			*121758005*
Related Category 1 Project:	*121758005.1.1 Development of Behavioral Health Crisis Stabilization Services*		
Starting Point/Baseline:	*To Be Determined in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: written analysis and implementation plans approved by the BHLT Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2** [P-3]: Develop and Test Data Systems Data Source: Documentation of data system implementation and data reports from data system Process Milestone 2 Estimated Incentive Payment: $0	**Process Milestone 3 [P-4]:** Conduct PDSA cycles to improve data collection and intervention plans Data Source: monthly data reports and documentation of revisions to data collection & project interventions Process Milestone 3 Estimated Incentive Payment: $81,395 **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices to stakeholders Data Source: Quarterly data reports and narrative program updates Process Milestone 4 Estimated Incentive Payment: $81,395 **Process Milestone 5 [P-2]:** Establish Baseline Rates for Mental Health Admissions and Re-admissions to the Dallas County Jail Data Source: project data and Dallas County Jail data Process Milestone 5 Estimated Incentive Payment: $81,394	**Outcome Improvement Target 1** [IT-9.1]: Improvement Target: Decrease in mental health admissions and readmissions to the Dallas County Jail by 2% from baseline. Data Source: Dallas County Jail and project data records Outcome Improvement Target 1 Estimated Incentive Payment*:* $261,220	**Outcome Improvement Target 2** [IT-9.1]: Improvement Target: Decrease in mental health admissions and readmissions to the Dallas County Jail by 3% from baseline. Data Source: Dallas County Jail and project data records Outcome Improvement Target 2 Estimated Incentive Payment*:* $567,869

121758005.3.1	*3.IT-9.1*	*Decrease in Mental Health Admissions and Readmissions to Criminal Justice Settings*	
Dallas County			*121758005*
Related Category 1 Project:	*121758005.1.1 Development of Behavioral Health Crisis Stabilization Services*		
Starting Point/Baseline:	*To Be Determined in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $0	Year 3 Estimated Outcome Amount: $244,184	Year 4 Estimated Outcome Amount: $261,220	Year 5 Estimated Outcome Amount: $567,869
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,073,273			

Title of Outcome Measurement (Improvement Target): ED Appropriate Utilization for Persons in Behavioral Health Crisis

Unique RHP Outcome Identification Number: 121758005.3.2

Performing Provider Name/TPI: Dallas County/121758005

Outcome Measure Description

IT 9.2: ED Appropriate Utilization

ED Appropriate Utilization is directly related to the associated Category 1 project and captures the success of the Category 1 project in reducing emergency department utilization for persons in behavioral health (including substance abuse) crisis. In Dallas County, the utilization of emergency department services continues to increase while utilization of community-based crisis services had not increased at the same rate.

Process Milestones

DY2: P-1, Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
P-3, Develop and Test Data Systems

DY3: P-2, Establish Baseline Rates
P-4, Conduct PDSA cycles
P-5, Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets

DY4: IT 9.2 – Reduce Emergency Department Visits for persons in behavioral health crisis by 3.5% from baseline
DY5: IT 9.2 – Reduce Emergency Department Visits for persons in behavioral health crisis by 4.5% from baseline

Rationale

The core goal of the Category 1 project is to increase access to community-based services for persons in behavioral health crisis, with the associated decrease in the use of emergency departments for persons in crisis. The initial planning that will occur in DY 2 and DY 3 will inform and determine the baseline for the actual outcome targets for DY 4 and 5.

Outcome Measure Valuation

The outcome measure valuation is based upon reducing the number of persons who access emergency departments when in behavioral health crisis, with an associated increase in access to community-based (and lower cost) services. There is a specific cost to the local system each time a person accesses emergency department services. The planning work of DY 2 will inform that expected reduction in emergency department utilization (and the associated cost savings) during DY 4 and 5.

Related Category 1 or 2 Project

- 121758005.1.1: Develop behavioral health crisis stabilization services

121758005.3.2	*3.IT-9.2*	*Emergency Department Utilization for Behavioral Health/Substance Abuse*	
Dallas County			*121758005*
Related Category 1 Project:	*121758005.1.1 Development of Behavioral Health Crisis Stabilization Services*		
Starting Point/Baseline:	*To Be Determined in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: written analysis and implementation plans approved by the BHLT Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2** [P-3]: Develop and Test Data Systems Data Source: Documentation of data system implementation and data reports from data system Process Milestone 2 Estimated Incentive Payment: $0 *Add more process milestones/improvement targets, as applicable*	**Process Milestone 3 [P-4]:** Conduct PDSA cycles to improve data collection and intervention plans Data Source: monthly data reports and documentation of revisions to data collection/ project interventions Process Milestone 3 Estimated Incentive Payment: $81,395 **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices to stakeholders Data Source: Quarterly data reports and narrative program updates Process Milestone 4 Estimated Incentive Payment: $81,395 **Process Milestone 5 [P-2]:** Establish Baseline Rates for ED Utilization for persons in behavioral health crisis Data Source: project & hospital data Process Milestone 5 Estimated Incentive Payment: $81,394	**Outcome Improvement Target 1** [IT-1.1]: Improvement Target: Reduce Emergency Department Visits for persons in behavioral health/substance abuse crisis by 3.5% from baseline. Data Source: hospital and project data records Outcome Improvement Target 1 Estimated Incentive Payment*:* $261,220	**Outcome Improvement Target 2** [IT-1.1]: Improvement Target: Reduce Emergency Department Visits for persons in behavioral health/substance abuse crisis by 4.5% from baseline. Data Source: hospital and project data records Outcome Improvement Target 2 Estimated Incentive Payment*:* $567,870
Year 2 Estimated Outcome Amount: $0	Year 3 Estimated Outcome Amount: $244,184	Year 4 Estimated Outcome Amount: $261,220	Year 5 Estimated Outcome Amount: $567,870
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,073,274			

Title of Outcome Measure (Improvement Target): IT-11.2: Improvement in disparate health outcomes for target population, including identification of the disparity gap

Unique RHP outcome identification number(s): 121758005.3.3

Performing Provider Name/TPI: Dallas County/121758005

Outcome Measure Description

IT-11.2: Improvement in disparate health outcomes for target population including identification of disparity gap

- Numerator (TBD by Performing Provider): Pre Assessment Score Average
- Denominator (TBD by Performing Provider): Post Assessment Score Average

Process Milestones

- DY2:
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans
- DY3:
  - P-2: Establish base line
  - P-5: Disseminate findings, including lessons learned

Outcome Improvement Targets for each year

- DY4:
  - IT-11.2: Improvement in disparate health outcomes for target population including identification of disparity gap. Goal is 5% improvement on pre-assessment scores

- DY5:
  - IT-11.2: Improvement in disparate health outcomes for target population including identification of disparity gap. Goal is 10% improvement on pre-assessment scores

Rationale

The rate of testing of new solutions and ideas is one of the greatest predictors of the success of health education improvement efforts. According to the USPSTF, high intensity behavioral counseling among adults at increased risk for STIs reduces the incidence of STIs. These health promotion interventions can include those offered through multiple sessions, in groups, and/or before and after screening. DCHHS will use epidemiology surveillance data as the evidence-base to determine counseling locations and intervention population.

Outcome Measure Valuation

The rationale for valuing the project is based on community benefit due to decreasing preventable hospitalizations. Each health promotion participant was calculated to be one less person entering into the local healthcare delivery system.

The following valuation is based on a literature review of various community health worker/health educator interventions that include economic impact analyses. The example interventions are population-based in the community setting with consistent costs, and do not include hospital-based treatment and equipment interventions that would display increased cost variability.

Valuation examples are from: Social return on investment: Community Health Workers in cancer outreach, American Cancer Society Midwest Division (2012); Community Health Workers in Massachusetts: Improving Health Care and Public Health, Massachusetts Department of Health, Office of Community Health Workers (2009); and Outcomes of Community Health Worker Interventions, Agency for Healthcare Research and Quality (2009).

The DCHHS approach for valuing the first outcome measure is based on financial and human capital resources governing the capacity of the health department to implement a health promotion program that required planning, travel, and new staff.

Unique Category 3 ID: ***121758005.3.3***	***Ref Number from RHP PP:*** *3.IT-11.2*	*Improvement in disparate health outcomes for target population including identification of disparity gap*	
	Performing Provider: Dallas County		*TPI: 121758005*
Related Category 1 or 2 Projects:	*121758005.2.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans Process Milestone 1 Estimated Incentive Payment (max amount): $0	**Process Milestone 2** [P-2]: Establish baseline Data Source: documentation Process Milestone 2 Estimated Incentive Payment (max amount): $6704 **Process Milestone 3** [P-5]: Disseminate findings, including lessons learned Process Milestone 3 Estimated Incentive Payment (max amount): $6704	**Outcome Improvement Target 1** [IT-11.2]: Improvement in disparate health outcomes for target population including identification of disparity gap Outcome Improvement Target 1 Numerator: Pre Assessment Score Average (9 ZIP codes; Denominator: Post Assessment Score Average Goal: 5% improvement on pre versus post assessment scores) Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Estimated Incentive Payment (max amount): $14,343	**Outcome Improvement Target 2** [IT-11.2]: Improvement in disparate health outcomes for target population including identification of disparity gap Outcome Improvement Target 2 Numerator: Pre Assessment Score Average (12 ZIP codes) Denominator: Post Assessment Score Average Goal: 10% improvement on pre versus post assessment scores.) Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Estimated Incentive Payment (max amount): $31,181
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $13,408	Year 4 Estimated Outcome Amount: $14,343	Year 5 Estimated Outcome Amount: $31,181
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $ 58,932			

Title of Outcome Measure (Improvement Target): IT-11.3: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity

Unique RHP outcome identification number(s): 121758005.3.4

Performing Provider Name/TPI: Dallas County/ 121758005

Outcome Measure Description

IT-11.3: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity

- Numerator (TBD by Performing Provider): Pre Assessment Score Average
- Denominator (TBD by Performing Provider): Post Assessment Score Average

Process Milestones

- DY2:
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans
- DY3:
  - P-2: Establish base line

Outcome Improvement Targets for each year

- DY4:
  - IT-11.3: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. Goal is 5% improvement from pre-assessment scores
- DY5:
  - IT-11.3: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. Goal is 10% improvement from pre-assessment scores

Rationale

Determined utilization rates will be based on self-reporting of screening intentions in the pre and post assessments. The rate of testing of new solutions and ideas is one of the greatest

predictors of the success of health education improvement efforts. According to the USPSTF, high intensity behavioral counseling among adults at increased risk for STIs reduces the incidence of STIs. These health promotion interventions can include those offered through multiple sessions, in groups, and/or before and after screening. DCHHS will use epidemiology surveillance data as the evidence-base to determine counseling locations and intervention population.

Outcome Measure Valuation

The rationale for valuing the project is based on community benefit due to decreasing preventable hospitalizations. Each health promotion participant was calculated to be one less person entering into the local healthcare delivery system.

The following valuation is based on a literature review of various community health worker/health educator interventions that include economic impact analyses. The example interventions are population-based in the community setting with consistent costs, and do not include hospital-based treatment and equipment interventions that would display increased cost variability.

Valuation examples are from: Social return on investment: Community Health Workers in cancer outreach, American Cancer Society Midwest Division (2012); Community Health Workers in Massachusetts: Improving Health Care and Public Health, Massachusetts Department of Health, Office of Community Health Workers (2009); and Outcomes of Community Health Worker Interventions, Agency for Healthcare Research and Quality (2009).

The DCHHS approach for valuing the first outcome measure is based on financial and human capital resources governing the capacity of the health department to implement a health promotion program that required planning, travel, and new staff.

Unique Category 3 ID: ***121758005.3.4***	***Ref Number from RHP PP:*** *3.IT-11.3*	*Improvement in disparate health outcomes for target population (Disease Outbreaks and Sentinel Events Education)*	
	Performing Provider: Dallas County		*TPI: 121758005*
Related Category 1 or 2 Projects:	*121758005.2.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans Process Milestone 1 Estimated Incentive Payment (max amount): $0	**Process Milestone 2** [P-2]: Establish baseline Data Source: documentation Process Milestone 2 Estimated Incentive Payment (max amount): $13,408	**Outcome Improvement Target 1** [IT.11-3]: Improvement in disparate health outcomes for target population (Disease Outbreaks and Sentinel Events Education) Outcome Improvement Target 1 Baseline/Goal: Numerator: Pre Assessment Score Average (9 ZIP codes; Goal: 5% improvement on pre versus post assessment scores) Denominator: Post Assessment Score Average Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Estimated Incentive Payment (max amount): $14,343	**Outcome Improvement Target 2** [IT-11.3]: Improvement in disparate health outcomes for target population (Disease Outbreaks and Sentinel Events Education) Outcome Improvement Target 2 Goal: Numerator: Pre Assessment Score Average (12 ZIP codes; Goal: 10% improvement on pre versus post assessment scores.) Denominator: Post Assessment Score Average Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Estimated Incentive Payment (max amount): $31,181
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $13,408	Year 4 Estimated Outcome Amount: $14,343	Year 5 Estimated Outcome Amount: $31,181
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $ 58,932			

Title of Outcome Measure (Improvement Target): IT-12.5: Other USPSTF-endorsed screening outcome measure

The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections for adults at increased risk for STIs.

Unique RHP outcome identification number(s): 121758005.3.5

Outcome Measure Description

IT-12.5: Other USPSTF-endorsed screening outcome measure

- Numerator (TBD by Performing Provider): Behavioral Counseling Pre Assessment Score Average
- Denominator (TBD by Performing Provider): Behavioral Counseling Post Assessment Score Average

Process Milestones

- DY2:
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans
- DY3:
  - P-2: Establish base line

Outcome Improvement Targets for each year

- DY4:
  - I-12.5: Other USPSTF-endorsed screening outcome measure: Behavioral Counseling Assessment Score Average. Goal is 5% improvement on Pre-Assessment Scores
- DY5:
  - I-12.5: Other USPSTF-endorsed screening outcome measure: Behavioral Counseling Score Average. Goal is 10% improvement on Pre-Assessment Scores

Rationale

The rate of testing of new solutions and ideas is one of the greatest predictors of the success of health education improvement efforts. According to the USPSTF, high intensity behavioral counseling among adults at increased risk for STIs reduces the incidence of STIs. These health promotion interventions can include those offered through multiple sessions, in groups, and/or before and after screening. DCHHS will use epidemiology surveillance data as the evidence-base to determine counseling locations and intervention population.

Outcome Measure Valuation

The rationale for valuing the project is based on community benefit due to decreasing preventable hospitalizations. Each health promotion participant was calculated to be one less person entering into the local healthcare delivery system.

The following valuation is based on a literature review of various community health worker/health educator interventions that include economic impact analyses. The example interventions are population-based in the community setting with consistent costs, and do not include hospital-based treatment and equipment interventions that would display increased cost variability.

Valuation examples are from: Social return on investment: Community Health Workers in cancer outreach, American Cancer Society Midwest Division (2012); Community Health Workers in Massachusetts: Improving Health Care and Public Health, Massachusetts Department of Health, Office of Community Health Workers (2009); and Outcomes of Community Health Worker Interventions, Agency for Healthcare Research and Quality (2009).

The DCHHS approach for valuing the first outcome measure is based on financial and human capital resources governing the capacity of the health department to implement a health promotion program that required planning, travel, and new staff.

Unique Category 3 ID: ***121758005.3.5***	***Ref Number from RHP PP:*** *3.IT-12.5*	*Other USPSTF-endorsed screening outcome measure: Behavioral Counseling Assessment*	
Performing Provider: Dallas County			*TPI: 121758005*
Related Category 1 or 2 Projects:	*121758005.2.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans Process Milestone 1 Estimated Incentive Payment (max amount): $0	**Process Milestone 2** [P-2]: Establish baseline Data Source: documentation Process Milestone 2 Estimated Incentive Payment (max amount): $4,469	**Outcome Improvement Target 1** [IT.12-5]: Other USPSTF-endorsed screening outcome measure: Behavioral Counseling Assessment Outcome Improvement Target 1 Numerator: Pre Assessment Score Average (24 community sites) Denominator: Post Assessment Score Average Goal: 5% improvement on pre versus post assessment scores Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Estimated Incentive Payment (max amount): $4,782	**Outcome Improvement Target 2** [IT12.5]: Other USPSTF-endorsed screening outcome measure: Behavioral Counseling Assessment Outcome Improvement Target 2 Numerator: Pre Assessment Score Average (30 community sites) Denominator: Post Assessment Score Average Goal: 10% improvement on pre versus post assessment scores Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Estimated Incentive Payment (max amount): $10,394
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $4,469	Year 4 Estimated Outcome Amount: $4,782	Year 5 Estimated Outcome Amount: $10,394
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $19,645			

Title of Outcome Measure (Improvement Target): IT-11.2: Improvement in disparate health outcomes for target population, including identification of the disparity gap

Unique RHP outcome identification number(s): 121758005.3.6

Performing Provider Name/TPI: Dallas County/ 121758005

Outcome Measure Description

IT-11.2: Improvement in disparate health outcomes for target population including identification of disparity gap

- Numerator (TBD by Performing Provider): Pre Assessment Score Average
- Denominator (TBD by Performing Provider): Post Assessment Score Average

Process Milestones

- DY2:
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans
- DY3:
    - P-2: Establish base line
    - P-5: Disseminate findings, including lessons learned

Outcome Improvement Targets for each year

- DY4:
    - IT-11.2: Improvement in disparate health outcomes for target population including identification of disparity gap. Goal is 5% improvement on pre-assessment scores

- DY5:
    - IT-11.2: Improvement in disparate health outcomes for target population including identification of disparity gap. Goal is 10% improvement on pre-assessment scores

Rationale

The rate of testing of new solutions and ideas is one of the greatest predictors of the success of health education improvement efforts. According to the USPSTF, high intensity behavioral counseling among adults at increased risk for STIs reduces the incidence of STIs. These health promotion interventions can include those offered through multiple sessions, in groups, and/or before and after screening. DCHHS will use epidemiology surveillance data as the evidence-base to determine counseling locations and intervention population.

Outcome Measure Valuation

The rationale for valuing the project is based on community benefit due to decreasing preventable hospitalizations. Each health promotion participant was calculated to be one less person entering into the local healthcare delivery system.

The following valuation is based on a literature review of various community health worker/health educator interventions that include economic impact analyses. The example interventions are population-based in the community setting with consistent costs, and do not include hospital-based treatment and equipment interventions that would display increased cost variability.

Valuation examples are from: Social return on investment: Community Health Workers in cancer outreach, American Cancer Society Midwest Division (2012); Community Health Workers in Massachusetts: Improving Health Care and Public Health, Massachusetts Department of Health, Office of Community Health Workers (2009); and Outcomes of Community Health Worker Interventions, Agency for Healthcare Research and Quality (2009).

The DCHHS approach for valuing the first outcome measure is based on financial and human capital resources governing the capacity of the health department to implement a health promotion program that required planning, travel, and new staff.

Unique Category 3 ID: ***121758005.3.6***	***Ref Number from RHP PP:*** *3.IT-1.2*	*Improvement in disparate health outcomes for target population including identification of disparity gap*	
	Performing Provider: Dallas County		*TPI: 121758005*
Related Category 1 or 2 Projects:	*121758005.2.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans Process Milestone 1 Estimated Incentive Payment (max amount): $0	**Process Milestone 2** [P-2]: Establish baseline Data Source: documentation Process Milestone 2 Estimated Incentive Payment (max amount): $2234 **Process Milestone 3** [P-5]: Disseminate findings, including lessons learned Process Milestone 3 Estimated Incentive Payment (max amount): $2235	**Outcome Improvement Target 1** [IT11.2]: Improvement in disparate health outcomes for target population including identification of disparity gap Outcome Improvement Target 1 Numerator: Pre Assessment Score Average (9 ZIP codes) Denominator: Post Assessment Score Average Goal: 5% improvement on pre versus post assessment scores Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Estimated Incentive Payment (max amount): $4,782	**Outcome Improvement Target 2** [IT-11.2]: Improvement in disparate health outcomes for target population including identification of disparity gap Outcome Improvement Target 2 Numerator: Pre Assessment Score Average (12 ZIP codes) Denominator: Post Assessment Score Average Goal: 10% improvement on pre versus post assessment scores Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Estimated Incentive Payment (max amount): $10,394
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $4,469	Year 4 Estimated Outcome Amount: $4,782	Year 5 Estimated Outcome Amount: $10,394

Unique Category 3 ID: ***121758005.3.6***	***Ref Number from RHP PP:*** *3.IT-1.2*	*Improvement in disparate health outcomes for target population including identification of disparity gap*	
Performing Provider: Dallas County			*TPI: 121758005*
Related Category 1 or 2 Projects:	*121758005.2.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $19,645			

Title of Outcome Measure (Improvement Target): IT-11.3: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity

Unique RHP outcome identification number(s): 121758005.3.7

Performing Provider Name/TPI: Dallas County/ 121758005

Outcome Measure Description

IT-11.3: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity

- Numerator (TBD by Performing Provider): Pre Assessment Score Average
- Denominator (TBD by Performing Provider): Post Assessment Score Average

Process Milestones

- DY2:
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans
- DY3:
  - P-2: Establish base line

Outcome Improvement Targets for each year

- DY4:
  - IT-11.3: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. Goal is 5% improvement on pre-assessment scores
- DY5:
  - IT-11.3: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. Goal is 10% improvement on pre-assessment scores

Rationale

Determined utilization rates will be based on self-reporting of screening intentions in the pre and post assessments. The rate of testing of new solutions and ideas is one of the greatest predictors of the success of health education improvement efforts. According to the USPSTF, high intensity behavioral counseling among adults at increased risk for STIs reduces the incidence of STIs. These health promotion interventions can include those offered through multiple sessions, in groups, and/or before and after screening. DCHHS will use epidemiology surveillance data as the evidence-base to determine counseling locations and intervention population.

Outcome Measure Valuation

The rationale for valuing the project is based on community benefit due to decreasing preventable hospitalizations. Each health promotion participant was calculated to be one less person entering into the local healthcare delivery system.

The following valuation is based on a literature review of various community health worker/health educator interventions that include economic impact analyses. The example interventions are population-based in the community setting with consistent costs, and do not include hospital-based treatment and equipment interventions that would display increased cost variability.

Valuation examples are from: Social return on investment: Community Health Workers in cancer outreach, American Cancer Society Midwest Division (2012); Community Health Workers in Massachusetts: Improving Health Care and Public Health, Massachusetts Department of Health, Office of Community Health Workers (2009); and Outcomes of Community Health Worker Interventions, Agency for Healthcare Research and Quality (2009).

The DCHHS approach for valuing the first outcome measure is based on financial and human capital resources governing the capacity of the health department to implement a health promotion program that required planning, travel, and new staff.

Unique Category 3 ID: ***121758005.3.7***	***Ref Number from RHP PP:*** *3.IT-11.3*	*Improvement in disparate health outcomes for target population (Disease Outbreaks and Sentinel Events Education)*	
Performing Provider: Dallas County			*TPI: 121758005*
Related Category 1 or 2 Projects:	*121758005.2.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans Process Milestone 1 Estimated Incentive Payment (max amount): $0	**Process Milestone 2** [P-2]: Establish baseline Data Source: documentation Process Milestone 2 Estimated Incentive Payment (max amount): $4,470	**Outcome Improvement Target 1** [IT.11-3]: Improvement in disparate health outcomes for target population (Disease Outbreaks and Sentinel Events Education) Outcome Improvement Target 1 Numerator: Pre Assessment Score Average (9 ZIP codes) Denominator: Post Assessment Score Average Goal: 5% improvement on pre versus post assessment scores Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Estimated Incentive Payment (max amount): $4,781	**Outcome Improvement Target 2** [IT-11.3]: Improvement in disparate health outcomes for target population (Disease Outbreaks and Sentinel Events Education) Outcome Improvement Target 2 Numerator: Pre Assessment Score Average (12 ZIP codes) Denominator: Post Assessment Score Average Goal: 10% improvement on pre versus post assessment scores Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Estimated Incentive Payment (max amount): $10,395
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $4,470	Year 4 Estimated Outcome Amount: $4,781	Year 5 Estimated Outcome Amount: $10,395
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $19,646			

Title of Outcome Measure (Improvement Target): IT-12.5: Other USPSTF-endorsed screening outcome measure

The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections for adults at increased risk for STIs.

Unique RHP outcome identification number(s): 121758005.3.8

Performing Provider Name/TPI: 121758005

Outcome Measure Description

IT-12.5: Other USPSTF-endorsed screening outcome measure

- Numerator (TBD by Performing Provider): Behavioral Counseling Pre Assessment Score Average
- Denominator (TBD by Performing Provider): Behavioral Counseling Post Assessment Score Average

Process Milestones

- DY2:
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans
- DY3:
  - P-2: Establish base line

Outcome Improvement Targets for each year

- DY4:
  - I-12.5: Other USPSTF-endorsed screening outcome measure: Behavioral Counseling Pre Assessment and Post Assessment Score Averages. Goal: 5% improvement in pre-assessment scores
- DY5:
  - I-12.5: Other USPSTF-endorsed screening outcome measure: Behavioral Counseling Pre Assessment and Post Assessment Score Averages. Goal: 10% improvement in pre-assessment scores

Rationale

The rate of testing of new solutions and ideas is one of the greatest predictors of the success of health education improvement efforts. According to the USPSTF, high intensity behavioral counseling among adults at increased risk for STIs reduces the incidence of STIs. These health promotion interventions can include those offered through multiple sessions, in groups, and/or before and after screening. DCHHS will use epidemiology surveillance data as the evidence-base to determine counseling locations and intervention population.

Outcome Measure Valuation

The rationale for valuing the project is based on community benefit due to decreasing preventable hospitalizations. Each health promotion participant was calculated to be one less person entering into the local healthcare delivery system.

The following valuation is based on a literature review of various community health worker/health educator interventions that include economic impact analyses. The example interventions are population-based in the community setting with consistent costs, and do not include hospital-based treatment and equipment interventions that would display increased cost variability.

Valuation examples are from: Social return on investment: Community Health Workers in cancer outreach, American Cancer Society Midwest Division (2012); Community Health Workers in Massachusetts: Improving Health Care and Public Health, Massachusetts Department of Health, Office of Community Health Workers (2009); and Outcomes of Community Health Worker Interventions, Agency for Healthcare Research and Quality (2009).

The DCHHS approach for valuing the first outcome measure is based on financial and human capital resources governing the capacity of the health department to implement a health promotion program that required planning, travel, and new staff.

Unique Category 3 ID: ***121758005.3.8***	***Ref Number from RHP PP:*** *3.IT-12.5*	*Other USPSTF-endorsed screening outcome measure: Behavioral Counseling Pre and Post Assessment Scores*	
Performing Provider: Dallas County			*TPI: 121758005*
Related Category 1 or 2 Projects:	*121758005.2.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans Process Milestone 1 Estimated Incentive Payment (max amount): $0	**Process Milestone 2** [P-2]: Establish baseline Data Source: documentation Process Milestone 2 Estimated Incentive Payment (max amount): $13,408	**Outcome Improvement Target 1** [IT.12-5]: Other USPSTF-endorsed screening outcome measure: Behavioral Counseling Assessment Outcome Improvement Target 1 Numerator: Pre Assessment Score Average (24 community sites) Denominator: Post Assessment Score Average Goal: 5% improvement on pre versus post assessment scores Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Estimated Incentive Payment (max amount): $14,434	**Outcome Improvement Target 2** [IT-12.5]: Other USPSTF-endorsed screening outcome measure: Behavioral Counseling Assessment Outcome Improvement Target 2 Numerator: Pre Assessment Score Average (30 community sites) Denominator: Post Assessment Score Average Goal: 10% improvement on pre versus post assessment scores Data Source: Health Promotion Meeting Attendance, Pre/Post Participant Surveys) Estimated Incentive Payment (max amount): $31,181
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $13,408	Year 4 Estimated Outcome Amount: $14,343	Year 5 Estimated Outcome Amount: $31,181
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $58,932			

Title of Outcome Measure: OD-6 Patient Satisfaction

Unique RHP Outcome Identification Number: 137252607.3.1

Performing Provider Name/TPI: Dallas County MHMR Center dba Metrocare Services/137252607

Outcome Measure Description

OD-6 Patient Satisfaction
IT-6.1 Patient Satisfaction

Process Milestones:

Year 2

- [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans

  Metric: Develop Gantt chart for timelines and use information gathering to complete program policies and procedures
  Goal: Complete project planning stage including Gantt chart for organizing timelines and Program Policy and Procedures to formalize prioritizes and operations
  Data Source: Metrocare Management Team

Year 3

- [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

  Metric: Quality Management Department will use real time data for rapid cycle improvement to guide continuous quality improvement
  Goal: Routinely improve program operations and therapeutic interventions by implementing recommended changes from Quality Management
  Data Source: Audits conducted monthly by Quality Management Department

Year 4

- [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

  Metric: Quality Management Department will use real time data for rapid cycle improvement to guide continuous quality improvement
  Goal: Routinely improve program operations and therapeutic interventions by implementing recommended changes from Quality Management
  Data Source: Audits conducted monthly by Quality Management Department

- **Outcome Improvement Target 1**

  IT-6.1: Patient Satisfaction
  Numerator: Overall patient satisfaction score for all domains for patients that have been treated by a CER student and/or resident
  Denominator: Overall patient satisfaction score for all domains for patients that have not been treated by a CER student or resident
  Goal: 10% increase in overall patient satisfaction scores.
  Data source: Patient Survey

  Year 5

- [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

  Metric: Quality Management Department will use real time data for rapid cycle improvement to guide continuous quality improvement
  Goal: Routinely improve program operations and therapeutic interventions by implementing recommended changes from Quality Management
  Data Source: Audits conducted monthly by Quality Management Department

- **Outcome Improvement Target 2**

  IT-6.1: Patient Satisfaction
  Numerator: Overall patient satisfaction score for all domains for patients that have been treated by a CER student and/or resident
  Denominator: Overall patient satisfaction score for all domains for patients that have not been treated by a CER student or resident
  Goal: 20% increase in overall patient satisfaction scores.

Rationale:

By collaboratively intertwining present day evidence based education with real world interventions and supervision along with Metrocare's dynamic array of clinical services we are proposing that clients with have higher satisfaction scores compared to clients that do not receive services from one of our residents/trainees.

This protocol was chosen in order to connect the training and increase in number of professionals employed to serve the medically indigent client back to an emphasis on patient satisfaction.

The CER must remain focused not only on high quality training of best clinical practices but also on tracking and monitoring patient satisfaction scores. Patient satisfaction scores should lead our trainees in understanding that a patient whom is engaged and satisfied with his/her treatment is more likely to remain stable and use less intensive services than a patient whom is not satisfied with his or her care.
The CER is confident that the collaborative nature of combining mental health classroom education with a real world experience using evidence based practices along with supervision will produce higher satisfaction scores in the clients that have been treated by a resident and/or student versus a client that has not been treated by a student and/or resident.

Outcome Measure Valuation:

The true value of the Behavioral Health Workforce Initiative will be realized in the future. Identifying the declining deficit of qualified mental health professionals now, highlights the issue and allows the community to address the problem and work on a solution. Workforce issues and provider availability are becoming a major issue. In 2010, 95% of Texas psychiatrists enrolled as Medicaid providers were not accepting new patients. As the population continues to increase, the availability of a workforce to handle the growing number of patients will worsen without appropriate intervention to expand the number of practitioners.

Metrocare Services determined the value of each project by comparing the budgeted cost of the specific project against the cost to the community should the services go un-provided. In regards to the workforce enhancement we assessed the cost of training each individual resident/trainee due to the lack of productivity taken away from the supervising clinician in addition to cost of paying the various institutions to have their students on site at Metrocare. We project that 10% of those that participate in DY 4 will report improved satisfaction scores and 20% of participants in DY 5 will report improvement in satisfaction scores.

137252607.3.1	IT-6.1	Patient Satisfaction	
Dallas County MHMR Center dba Metrocare Services			137252607
Related Category 1 or 2 Projects:	137252607.1.1 – *Behavioral Health Workforce Development Program*		
Starting Point/Baseline:	***Percent improvement over baseline.*** ***Target Population:*** Medically indigent clients along with current mental health students being educated to become: psychiatrists, licensed psychologists, nurse practitioners, physicians assistants, nurses, social workers, licensed professional counselors, licensed marriage and family therapists, licensed chemical dependency counselors, and peer support specialists.		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans Metric: Develop Gantt chart for timelines and use information gathering to complete program policies and procedures Goal: Complete project planning stage including Gantt chart for organizing timelines and Program Policy and Procedures to formalize prioritizes and operations Data Source: Metrocare Management Team Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 0	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Quality Management Department will use real time data for rapid cycle improvement to guide continuous quality improvement Goal: Routinely improve program operations and therapeutic interventions by implementing recommended changes from Quality Management Data Source: Audits conducted monthly by Quality Management Department Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 18,449 **Outcome Improvement Target 1**	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Quality Management Department will use real time data for rapid cycle improvement to guide continuous quality improvement Goal: Routinely improve program operations and therapeutic interventions by implementing recommended changes from Quality Management Data Source: Audits conducted monthly by Quality Management Department Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 27,351	**Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Quality Management Department will use real time data for rapid cycle improvement to guide continuous quality improvement Goal: Routinely improve program operations and therapeutic interventions by implementing recommended changes from Quality Management Data Source: Audits conducted monthly by Quality Management Department Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $ 72,506

137252607.3.1	IT-6.1	Patient Satisfaction	
Dallas County MHMR Center dba Metrocare Services			137252607
Related Category 1 or 2 Projects:	137252607.1.1 – *Behavioral Health Workforce Development Program*		
Starting Point/Baseline:	***Percent improvement over baseline.*** ***Target Population:*** Medically indigent clients along with current mental health students being educated to become: psychiatrists, licensed psychologists, nurse practitioners, physicians assistants, nurses, social workers, licensed professional counselors, licensed marriage and family therapists, licensed chemical dependency counselors, and peer support specialists.		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	IT-6.1: Improvement in patient satisfaction score related to all domains for patients who have been treated by a student and/or resident. Numerator: Percent improvement in targeted patients for all domains. Denominator: Number of patients who were administered the survey and were treated by a student and/or resident in year 3. Goal: 10% of patients satisfied with treatment as measures for all domains for patient satisfaction scores. Data source: CAHPS Clinician & Group Survey **Estimated Incentive Payment: $18,449**	**Outcome Improvement Target 2** IT-6.1: Improvement in patient satisfaction score related to all domains for patients who have been treated by a student and/or resident. Numerator: Percent improvement in targeted patients for all domains. Denominator: Number of patients who were administered the survey and were treated by a student and/or resident in year 4. Goal: 20% increase in overall patient satisfaction scores. Data source: CAHPS Clinician & Group Survey **Estimated Incentive Payment: $27,351**	**Outcome Improvement Target 3** **Outcome Improvement Target 3** IT-6.1: Improvement in patient satisfaction score related to all domains for patients who have been treated by a student and/or resident. Numerator: Percent improvement in targeted patients for all domains. Denominator: Number of patients who were administered the survey and were treated by a student and/or resident in year 5. Goal: 40% increase in overall patient satisfaction scores. Data source: CAHPS Clinician & Group Survey **Estimated Incentive Payment: $72,506**
Year 2 Estimated Outcome Amount: $ 0	Year 3 Estimated Outcome Amount: $ 36,898	Year 4 Estimated Outcome Amount: $54,702	Year 5 Estimated Outcome Amount: $145,012
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $236,612			

Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP Outcome Identification Number: 137252607.3.2

Performing Provider name/TPI: Dallas County MHMR Center dba Metrocare Services/137252607

Outcome Measure Description:
OD-1: Primary Care and Chronic Disease Management

IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (standalone measure)

a. Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP ,140/90mm HG) during the measurement year

b. Denominator: Patients 18-85 years of age as of December 31 or the measurement year with a diagnosis of hypertension

c. Data Source: Electronic Medical record

d. Rationale: Approximately76.4 million (33.5%) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure.. A pool of past clinical trials demonstrated that 5 to 6mm reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14% to 20% reduction in mortality from coronary heart disease. Literature from clinical trial indicates that 53 % to 75% of people under treatment achieved control of their blood pressure. Specifications of this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee.

Process Milestones:

DY 2

- P-1 Project Planning : identify Metrocare community mental health clinic sites which will accommodate the integration of physical health services in conjunction with previously existing behavioral health services at those sites. Sites will be assessed by Metrocare's facilities department for adequacy of physical space in the clinics, parking availability, access to public transportation (bus/train lines) and access by easily

navigated roads and freeways. Metrocare's Human Resources department will recruit and hire primary care physicians, advanced nurse practitioners, and RN's. Emphasis will be placed on hiring primary care providers who are willing to work with persons who have severe and persistent mental illnesses and developmental disabilities in a team-oriented environment.

DY 3

- P-2 Establish baseline rates: establish baseline rates of hypertension in people with diagnoses of severe and persistent mental illness in two existing Metrocare community mental health clinics which have been integrated to provide onsite primary health care in collaboration with behavioral healthcare services

- **Rationale:** Establishment of a co-located integrated care setting will allow persons who are being seen for services to have blood pressure monitoring at every appointment. Should elevations in blood pressure be found, that person will be able to access physical healthcare, and receive appropriate interventions on the same day he/she is being seen for a mental health service. These interventions would include preventive care and wellness education, such as dietary management and smoking cessation groups, as well as medication management when necessary. Metrocare's on-site pharmacies will allow patients who need medication, to obtain the same day. DY 3 will allow us to gather information on baseline rates of hypertension in 1500 persons with severe and persistent mental illness and treat appropriately.

DY 4 and 5

Continue systematic measuring of blood pressures on people receiving integrated healthcare services at Metrocare community clinics with a treatment goal of blood pressure maintenance <140/90. Continue and expand wellness programming and preventive interventions, as well as medication interventions for those who are unable to achieve adequate control with diet and exercise. In years 4 and 5 of the project, we expect to improve total numbers of persons identified as having high blood pressure by 10% in year 4 and by 15% in year 5.

- **Outcome Measure Valuation:** By offering easy access to preventive services, case management, chronic disease management, health education, medication and care coordination, we will be able to reduce associated medical complications of untreated hypertension and reduce associated costs of utilization for higher levels of care. A randomized trial study by Druss et al in 2001 showed that integrated medical care in

patients with serious psychiatric illness have increased preventive care utilization and greater improvement in health (Druss et.al.,2001).

We based our valuations on the IMPACT research trials which showed greater quality outcomes and improved health care costs. Long term savings on health care costs (4 yr) were up to $3,363 per patient. They had lower health care cost in every category including but not limited to outpatient and inpatient medical and surgical costs, pharmacy costs and other outpatient costs.
(Mauer & Jarvis, 2010). Our goal is to serve 3500 clients by year five and the cost savings will be 3500x$3,363 = $11,770,500.

Rationale:

The national association of State Mental Health Program Directors (NASMHPD) study in 2006 showed that patients with serious mental illness have increased mortality rates 2.3 times higher than the general population due to heart disease, and 2.7 times higher than general population due to diabetes. (Parks et al, 2006). Randomized trials which evaluated integrated models of primary care were associated with improved quality and outcomes of medical care (Druss, B et al, 2001).

Heart disease and stroke are two of the leading causes of death in the United States. More than 800,000 Americans die from heart attacks and strokes each year(Center for Disease Control). With primary care integration at our mental health clinics, we expect improvement in Category 3 standalone measures such as Controlling High Blood Pressure.

Persons with high blood pressure are at risk for a number of health complications (Mayo Foundation). These include:

- Heart attack or stroke
- Aneurysm
- Heart failure
- Vision loss
- Associated metabolic syndrome
- Trouble with memory or understanding

Data shows that lowering blood pressure by as little as 5 points can result in a 16% reduction in coronary heart disease and a 42 % reduction in strokes (SAMHSA-HRSA Center for Integrated Health Solutions).

References

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SAMSHA-HRSA Center for Integrated Health Solutions. *www.integration.samhsa.gov ›*

137252607.3.2	*IT-1.7*	**Controlling High Blood Pressure**	
Metrocare services			*137252607*
Related Category 1 or 2 Projects:	*1372526072.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 **P-1** **Project planning**-engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans **Metric:** Evaluation of existing Metrocare outpatient community mental health clinics which are suitable for integration of co-located primary care services **Goal**: Identify and integrate behavioral and physical healthcare at one clinic site. Hire a primary care physician, advanced nurse practitioner, and RN **Data Source**: Metrocare facilities department; Metrocare Human Resources department **Process Milestone 1 Estimated Incentive Payment: $ 0**	**Process Milestone 2** **P-2** Establish baseline rates **Metric:** check blood pressures on all patients who are coming in for behavioral or physical healthcare services **Goal:** Establish baselines rate of persons with severe and persistent mental illness who have blood pressure readings >140/90 **Data Source:** Metrocare Electronic Health record **Estimated Incentive Payment** (maximum amount): $49,727 **Outcome Improvement Target 1** IT-1.7 Controlling high blood pressure **Metric**: Percentage of people showing Improved blood pressure readings >140/90 **Goal:** 5 % improvement over numbers of people with baseline in blood pressure measurements >140/90 **Data Source:** Metrocare electronic health record **Outcome Improvement Target 1** **Estimated Incentive Payment**: $49,728	**Outcome Improvement Target 2** IT-1.7 Controlling high blood pressure **Metric**: Percentage of people showing Improved blood pressure readings >140/90 **Goal:** 10 % improvement over numbers of people with baseline in blood pressure measurements >140/90 **Data Source:** Metrocare Electronic Health record **Estimated Incentive Payment: $148,613**	**Outcome Improvement Target 3** IT-1.7 Controlling blood pressure **Metric:** Improve blood pressure readings >140/90 **Goal:** Improvement Target: 15% improvement over numbers of people with baseline blood pressure readings >140/90 **Data Source:** Metrocare clinical system **Outcome Improvement Target 3** **Estimated Incentive Payment*:*** **$395,543**

137252607.3.2	*IT-1.7*	**Controlling High Blood Pressure**	
Metrocare services			*137252607*
Related Category 1 or 2 Projects:	*1372526072.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount $99,455	Year 4 Estimated Outcome Amount: $148,613	Year 5 Estimated Outcome Amount: $395,543
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$643,611**			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life

Unique RHP Outcome Identification Number: 137252607.3.3

Performing Provider Name/TPI: Dallas County MHMR Center dba Metrocare Services/ 137252607

Outcome Measure Description

IT – 10.1: Quality of Life

Process Milestones

- DY2:
  - P-1 Project planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities
- DY4:
  - P-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities
- DY5:
  - P-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year

- DY4:
  - I-10.1 Quality of Life
    - Numerator: Percent improvement in Quality of Life
    - Denominator: Number of patients who participated in ACT services
    - Goal: 25% of patients who participate in ACT services for will report improved quality of life
    - Data Source: Achenbach System of Empirically Based Assessment (ASEBA)
- DY5:
  - I-10.1 Quality of Life

- Numerator: Percent improvement in Quality of Life
- Denominator: Number of patients who participated in ACT services
- Goal: 50% of patients who participate in ACT services will report improved quality of life
- Data Source: Achenbach System of Empirically Based Assessment (ASEBA)

Rationale

Research indicates that adequate outpatient services decrease hospital use for behavioral health issues (SdosReis, et.al. 2008); thus intensive services that are comprehensive, offering multiple services to address the unique needs of the individual, must be provided. The services provided through ACT are proven effective at reducing hospitalizations and out-of-home placements while costing considerably less than expensive treatment episodes in the hospital, judicial system or residential treatment. For Category 3, the identified process milestones and improvement target were selected in order to measure the successful implementation and delivery of the ACT program. The goal of the program is to decrease potential readmission to psychiatric facilities, jails and state supported facilities by offering an intensive package of services that will stabilize the individual in the home/ community setting, increase their life skills and coping strategies and improve their overall quality of life. By choosing the identified milestones and improvement targets, Metrocare will be able to systematically monitor and evaluate the effectiveness of the treatment interventions and provide immediate changes to processes for continuous quality improvement.

Outcome Measure Valuation

Metrocare Services determined the value of each project by comparing the budgeted cost of the specific project against the cost to the community should the services go unprovided. In regards to the ACT Project, the significant cost of the hospitalization, emergency room visits, detainment in a and placement in a State Supported Living Facility were used as comparison data against cost for the community-based ACT Project. It is estimated that participation in ACT will result in less than 5% returning to the ER or hospital, less than 5% detained in jail and less than 2% placed in a State Supported Living Center. Metrocare projects that 25% of those that participate in ACT services in DY 4 will report improved quality of life and 50% of participants in DY 5 will report improvement in quality of life.

137252607.3.3	IT-10.1	Quality of Life	
Dallas County MHMR Center dba Metrocare Services			
Related Category 1 or 2 Projects:	137252607.2.2 – Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting – ACT (Assertive Community Team)		
Starting Point/Baseline:	**Baseline: 0** **Target Population: Individuals diagnosed with a developmental disability that are at risk for hospitalization, incarceration, and/or institutionalization.**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans Metric: Determine timeframe to administer Quality of Life Assessment and process for analysis of data Goal: Implement process for completing and analyzing ASEBA Data Source: Metrocare manual of operations, ASEBA Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 0	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process for Quality of Life Assessments (ASEBA) Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection through patient ASEBA assessments Data Source: manual of operations, ASEBA, Quality Management Department' Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $36,102	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process for Quality of Life Assessments (ASEBA) Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection through patient ASEBA assessments Data Source: manual of operations, ASEBA, Quality Management Department Process Milestone3 Estimated Incentive Payment *(maximum amount):* $18,380 **Outcome Improvement Target 1** IT-10.1: Quality of Life Goal: 25% of those surveyed will report improved quality of life.	**Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process for Quality of Life Assessments (ASEBA) Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection through patient ASEBA assessments Data Source: manual of operations, ASEBA, Quality Management Department Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $46,438 **Outcome Improvement Target 2** IT-10.1: Quality of Life Goal: 50% of those surveyed will report improved quality of life. Data

137252607.3.3	IT-10.1	Quality of Life	
Dallas County MHMR Center dba Metrocare Services			
Related Category 1 or 2 Projects:	137252607.2.2 – Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting – ACT (Assertive Community Team)		
Starting Point/Baseline:	**Baseline: 0** **Target Population: Individuals diagnosed with a developmental disability that are at risk for hospitalization, incarceration, and/or institutionalization.**		
Year 2 (10/1/2012 – 9/30/2013)	**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: ASEBA and Metrocare clinical system **Estimated Incentive Payment: $18,380**	source: ASEBA and Metrocare Clinical system **Estimated Incentive Payment:** $46,438
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):$ 0	Year 3 Estimated Outcome Amount: $ 36,102	Year 4 Estimated Outcome Amount: $ 36,760	Year 5 Estimated Outcome Amount: $ 92,876
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $ 165,738			

Title of Outcome Measure (Improvement Target): IT – 10.1: Quality of Life

Unique RHP Outcome Identification Number: 137252607.3.5

Performing Provider Name/TPI: Dallas County MHMR Center dba Metrocare Services/ 137252607

Outcome Measure Description

IT – 10.1: Quality of Life

Process Milestones

- DY2:
  - P-1 Project planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities
- DY4:
  - P-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities
- DY5:
  - P-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year

- DY4:
  - I-10.1 Quality of Life
    - Numerator: Percent improvement in Quality of Life
    - Denominator: Number of patients who participated in FPP for services for three months
    - Goal: 65% of patients who participate in FPP services for three months will report improved quality of life
    - Data Source: Child and Adolescent Needs and Strength Assessment
- DY5:
  - I-10.1 Quality of Life

- Numerator: Percent improvement in Quality of Life
- Denominator: Number of patients who participated in FPP for services for three months
- Goal: 75% of patients who participate in FPP services for three months will report improved quality of life
- Data Source: Child and Adolescent Needs and Strength Assessment

Rationale

The identified process milestones and improvement targets were selected in order to measure the successful implementation and delivery of the Family Preservation Program (FPP) program. The Process Milestones identified above are initial procedures that establish the clinics' ability to evaluate the selected Improvement Target. The goal of the program is to identify youth recently hospitalized or at-risk for permanent removal from home and to provide community based services to those youth to decrease out-of-treatment episodes by improving the youth and families overall functioning and quality of life. There are long lasting consequences to the youth, family and community at large when a child endures multiple hospitalizations or removal from home. There is also significant financial impact to the community for out-of-home treatment and reducing potential preventable admissions is a priority to our region. The Family Preservation Model is proven effective at reducing out-of-home treatment; aiding in stabilization of a youth in the home and increasing functioning and quality of life for those served by offering an intensive and comprehensive model of treatment to the client and family.

Outcome Measure Valuation

Metrocare Services determined the value of each project by comparing the budgeted cost of the specific project against the cost to the community should the services go unprovided. In regards to the FPP Project, the significant cost of hospitalization, emergency room visits, detainment in a juvenile facility, and placement in a Residential Treatment Center were used as comparison data against cost for the community-based FPP Project. The starting point/baseline for the program is zero, with a total census of 200 kids at the end of the year three. The total census of those served will increase each year by 40 children. It is estimated that participation in FPP will result in less than 10% returning to the ER or hospital, less than 5% involved with the juvenile l justice system, and less than 2% requiring placement in a Residential Treatment Center. For those that participate in the FPP program for three months, it is estimated that 65% will report improve quality of life by conclusion of services in year 4 and 75% will report improvement in year 5.

137252607.3.5	IT-10.1	Quality of Life	
Dallas County MHMR Center dba Metrocare Services			
Related Category 1 or 2 Projects::	137252607.2.3 – Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting – Family Preservation		
Starting Point/Baseline:	***Baseline: 0*** ***Target Population: Youth who have or at-risk for frequent involvement with psychiatric facilities, juvenile justice centers and residential treatment.***		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans Metric: Determine timeframe to administer Quality of Life Assessment and process for analysis of data Goal: Implement process for completing and analyzing Child and Adolescent Needs and Strengths Assessment (CANS) and Adult Needs and Strengths Assessment (ANSA) Data Source: Metrocare Manual of Operations; CANS/ANSA Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 0	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process of Quality of Life Assessments (CANS/ANSA) Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection through patient CANS/ANSA assessments Data Source: Metrocare Manual of Operations, CANS/ANSA, Quality Management Department Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $71,430	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process of Quality of Life Assessments (CANS/ANSA) Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection through patient CANS/ANSA assessments Data Source: Metrocare Manual of Operations, CANS/ANSA, Quality Management Department Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $40,382 **Outcome Improvement Target 1** IT-10.1: Quality of Life Goal: 65% of those surveyed will	**Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process of Quality of Life Assessments (CANS/ANSA) Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection through patient CANS/ANSA assessments Data Source: Metrocare Manual of Operations, CANS/ANSA, Quality Management Department Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $90,125 **Outcome Improvement Target 2** IT-10.1: Quality of Life Goal: 75% of those surveyed will

137252607.3.5	IT-10.1	Quality of Life	
Dallas County MHMR Center dba Metrocare Services			
Related Category 1 or 2 Projects::	137252607.2.3 – Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting – Family Preservation		
Starting Point/Baseline:	***Baseline: 0*** ***Target Population: Youth who have or at-risk for frequent involvement with psychiatric facilities, juvenile justice centers and residential treatment.***		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		report improved quality of life. Data source: CANS and Metrocare clinical system **Estimated Incentive Payment:** $40,382	report improved quality of life. Data source: CANS and Metrocare Clinical system **Estimated Incentive Payment:** $ 90,125
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):$ 0	Year 3 Estimated Outcome Amount: $71,430	Year 4 Estimated Outcome Amount: $ 80,764	Year 5 Estimated Outcome Amount: $ 180,250
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 332,444			

Title of Outcome Measure (Improvement Target): IT – 9.4 Other Outcome Improvement Target – Reduce intensive school services and out-of-home treatment episode

Unique RHP Outcome Identification Number: Metrocare/137252607.3.7

Performing Provider Name/TPI: Dallas County MHMR Center dba Metrocare Services/ 137252607

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-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities
- DY4:
  - P-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities
- DY5:
  - P-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year

- DY4:
  - IT-9.4: Right Care Right Setting Improvement Target: Decrease of intensive school services and out-of-home treatment episodes by 70% for those in service (source: Metrocare clinical system)
- DY5:
  - IT-9.4: Right Care Right Setting Improvement Target: Decrease of intensive school services and out-of-home treatment episodes by 80% (source: Metrocare clinical system)

Rationale

The identified process milestones and improvement targets were selected in order to measure the successful implementation and delivery of the Intensive Applied Behavior Analysis Program. The goal of the program is to lead each child to his or her potential through evidence based therapy founded on the principles of ABA. Additionally the program will provide behavioral services to increase self-reliance and improved functioning, thus decreasing the need for costly and intensive special education services. There are long lasting consequences to the youth, family, and community at large when a child with developmental disabilities does not receive the specialized therapies necessary to prepare them for their future. Children diagnosed with developmental disabilities have multiple needs and face multiple barriers. Research shows that these children often benefit from and have the best future outcomes when they receive intensive ABA training. There are limited intensive services available in Region 9 for people with developmental disabilities displaying extreme behaviors. Metrocare offers a graduated system of care for people with developmental disabilities and behavioral health issues. This project completes the continuum of care where gaps currently exist. The Intensive Applied Behavior Analysis Program will take a comprehensive, systematic approach to treating children with complex needs, providing intensive services to improve quality of life. Through the efforts of this program, there will be a reduction in the need for costly and intensive Special Education services, and a future reduction in unnecessary Emergency Department visits or placement in a State Supported Living Center. By choosing the identified milestones and improvement targets, Metrocare will be able to systematically monitor and evaluate the effectiveness of the treatment interventions and provide immediate changes to processes for continuous quality improvement.

Outcome Measure Valuation

Metrocare Services determined the value of each project by comparing the budgeted cost of the specific project against the cost to the community should the services go unprovided. In regards to the Intensive Applied Behavior Analysis program, the significant cost of special education services, emergency room visits, and placement in a State Supported Living Facility were used as comparison data against cost for the Intensive Applied Behavior Analysis Program. The starting point/baseline for the program is zero, with a total census of 46 at the end of the first year. It is estimated that participation in ABA services will result in less than 10% requiring a higher level of support through Special Education services and less than 2% requiring placement in a State Support Living Facility.

137252607.3.7	IT-9.4	Other outcome improvement target reduce intensive school service and out-of-home treatment episodes	
Dallas County MHMR Center dba Metrocare Services			
Related Category 1 or 2 Projects:	137252607.2.4 – Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting – Intensive Applied Behavior Analysis Program		
Starting Point/Baseline:	***Baseline: 0*** ***Target Population: Children on the autism spectrum and/or children with other developmental disabilities***		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans Metric: Determine timeframe and process for analysis of data Goal: Implement process for data collection and analysis to determine utilization rates of intensive school services and out of home treatment episodes Data Source: Metrocare Manual of Operations; Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 0	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process regarding utilization rates of intensive school services and out of home treatment episodes Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection Data Source: Metrocare Manual of Operations, Quality Management Department Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $36,429	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process regarding utilization rates of intensive school services and out of home treatment episodes Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection Data Source: Metrocare Manual of Operations, Quality Management Department Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $22,771 **Outcome Improvement Target 1** IT-9.4 Right Care, Right Setting Improvement Target Goal: Decrease of intensive school services and out-of-home treatment episodes by 70% for those in service	**Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process regarding utilization rates of intensive school services and out of home treatment episodes Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection Data Source: Metrocare Manual of Operations, Quality Management Department Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $51,049 **Outcome Improvement Target 2** IT-9.4 Right Care, Right Setting Improvement Target Goal: Decrease of intensive school services and out-of-home treatment episodes by 80%

137252607.3.7	IT-9.4	Other outcome improvement target reduce intensive school service and out-of-home treatment episodes	
Dallas County MHMR Center dba Metrocare Services			
Related Category 1 or 2 Projects:	137252607.2.4 – Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting – Intensive Applied Behavior Analysis Program		
Starting Point/Baseline:	***Baseline: 0*** ***Target Population: Children on the autism spectrum and/or children with other developmental disabilities***		
Year 2 (10/1/2012 – 9/30/2013)	**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: Metrocare clinical system **Estimated Incentive Payment: $22,771**	Data source: Metrocare clinical system) **Estimated Incentive Payment: $51,050**
Year 2 Estimated Outcome Amount: $0	Year 3 Estimated Outcome Amount: $ 36,429	Year 4 Estimated Outcome Amount: $ 45,542	Year 5 Estimated Outcome Amount: $102,099
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 184,070			

Title of Outcome Measure (Improvement Target): IT-6.1 Patient Satisfaction

Unique RHP outcome identification number(s): 137252607.3.8

Performing Provider Name/TPI: Dallas County MHMR Center dba Metrocare Services/ 137252607

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-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities
- DY4:
  - P-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities
- DY5:
  - P-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Target for each year

- DY 3
  - IT-6.1 Patient Satisfaction

    Percent improvement over baseline of patient satisfaction scores for Selected domains (timely care, appointments and information)
    Numerator: Percent improvement in targeted patient satisfaction Domain
    Denominator: Number of patients administered the survey
    - Goal: 60% of those surveyed will report patient satisfaction regarding timely care, appointments and information
    - Data Source: CAHPS
- DY 4

- IT-6.1 Patient Satisfaction

  Percent improvement over baseline of patient satisfaction scores for selected satisfaction domains (timely care, appointments and information)
  Numerator: Percent improvement in targeted patient satisfaction domain
  Denominator: Number of patients who were administered the survey
  - Goal: 70% of those surveyed will report patient satisfaction regarding timely care, appointments and information
  - Data Source: CAHPS – Consumer Assessment of Healthcare Providers and System

- DY 5
  - IT-6.1 Patient Satisfaction

    Percent improvement over baseline of patient satisfaction scores for selected satisfaction domains (timely care, appointments and information)
    Numerator: Percent improvement in targeted patient satisfaction domain
    Denominator: Number of patients who were administered the survey
    - Goal: 80% of those surveyed will report patient satisfaction regarding timely care, appointments and information
    - Data Source: CAHPS – Consumer Assessment of Healthcare Providers and System

Rationale

The identified process milestone and improvement targets were selected in order to measure the successful implementation and delivery of the Intensive Applied Behavior Analysis Program. The goal of the program is to lead each child to his or her potential through evidence based therapy founded on the principles of ABA. Additionally the program will provide behavioral services to increase self-reliance and improved functioning, thus decreasing the need for costly and intensive special education services. There are lasting consequences to the youth, family, and community at large when a child with developmental disabilities does not receive the specialized therapies necessary to prepare them for their future. Children diagnosed with developmental disabilities have multiple needs and face multiple barriers. Research shows that these children often benefit from and have the best future outcomes when they receive intensive ABA training. There are limited intensive services available in Region 9 for people with developmental disabilities displaying extreme behaviors. Metrocare offers a graduated system of care for people with developmental disabilities and behavioral health issues. This project completes the continuum of care where gaps currently exist. The Intensive Applied Behavior Analysis Program will take a comprehensive, systematic approach to treating children with complex needs, providing intensive services to improve quality of life. Through the efforts

of this program, there will be a reduction in the need for costly and intensive Special Education services, and a future reduction in unnecessary Emergency Department visits or placement in a State Supported Living facility. By choosing the identified milestones and improvement targets, Metrocare will be able to systematically monitor and evaluate the effectiveness of the treatment interventions and provide immediate changes to processes for continuous quality improvement. The Consumer Assessment of Healthcare Providers and Systems was the chosen survey because this tool has proven to be reliable and valid with results.

Outcome Measure Valuation

Metrocare determined the value of each project by comparing the budgeted cost of the specific project against the cost to the community should the service go unprovided. In regards to the Intensive Applied Behavior Analysis program, the significant cost of Special Education services, emergency room visits, and placement in a State Supported Living Center were used as comparison data against cost for the Intensive Applied Behavior Analysis program. The starting point/baseline for the program is zero, with a total census of 46 at the end of the first year. It is estimated that participation in ABA services will result in less than 10% requiring a higher level of support through Special Education services and less than 2% requiring placement in a State Supported Living Center in the future.

137252607.3.8	*3.IT-6.1*	*Patient Satisfaction*	
Dallas County MHMR Center dba Metrocare Services			*TPI: 137252607*
Related Category 1 or 2 Projects:	*137252607.2.4*		
Starting Point/Baseline:	*Baseline is zero*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans Metric: Determine timeframe to administer Patient Satisfaction Survey and process for analysis of data Goal: Implement process for completing and analyzing CAHPS Data Source: Metrocare Manual of Operations; CAHPS Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 0	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process of Patient Satisfaction Survey - CAHPS Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection Data Source: Metrocare Manual of Operations, CAHPS, Quality Management Department Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $18,215 **Outcome Improvement Target 1** [IT-6.1]: Improvement Target: Improvement in patient satisfaction score related to timely care, appointments and information. Numerator: Percent of improvement in targeted patient satisfaction domain (timely care, appointments and information)	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process of Patient Satisfaction Survey - CAHPS Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection Data Source: Metrocare Manual of Operations, CAHPS, Quality Management Department Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $22,771 **Outcome Improvement Target 2** [IT-6.1]: Improvement Target: Improvement in patient satisfaction score related to timely care, appointments and information. Numerator: Percent improvement in targeted patient satisfaction	**Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process of Patient Satisfaction Survey - CAHPS Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection Data Source: Metrocare Manual of Operations, CAHPS, Quality Management Department Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $51,049 **Outcome Improvement Target 3** [IT-6.1]: Improvement Target: Improvement in patient satisfaction score related to timely care, appointments, and information. Numerator: Percent improvement in targeted patient satisfaction domain (timely care, appointments and

137252607.3.8	*3.IT-6.1*	*Patient Satisfaction*	
Dallas County MHMR Center dba Metrocare Services			*TPI: 137252607*
Related Category 1 or 2 Projects:	*137252607.2.4*		
Starting Point/Baseline:	*Baseline is zero*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Denominator: Number of patients who were administered the survey and received ABA services in Year 3. Goal: 60% of patients will report satisfaction with services Data Source: CAHPS and Metrocare Clinical System Outcome Improvement Target 1 Estimated Incentive Payment: $18,214	domain (timely care, appointments and information). Denominator: Number of patients who were administered the survey and received ABA services in Year 4. Goal: 70% of patients will report satisfaction with services Data Source: CAHPS and Metrocare Clinical System. Outcome Improvement Target 2 Estimated Incentive Payment: $22,771	information). Denominator: Number of patients who were administered the survey and received ABA services in Year 5. Goal: 80% of patients will report satisfaction with services Data Source: CAHPS and Metrocare Clinical System. Outcome Improvement Target 3 Estimated Incentive Payment: $51,050
Year 2 Estimated Outcome Amount:$0	Year 3 Estimated Outcome Amount: $36,429	Year 4 Estimated Outcome Amount: $45,542	Year 5 Estimated Outcome Amount: $102,099
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 184,070			

Title of Outcome Measure (Improvement Target): IT – 10.1: Quality of Life

Unique RHP Outcome Identification Number: 137252607.3.9

Performing Provider Name/TPI: Dallas County MHMR Center dba Metrocare Services/ 137252607

Outcome Measure Description

IT – 10.1: Quality of Life

Process Milestones

- DY2:
  - P-1 Project planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities
- DY4:
  - P-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities
- DY5:
  - P-4 Conduct Plan DO Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year

- DY4:
  - I-10.1 Quality of Life
    - Numerator: Percent improvement in Quality of Life
    - Denominator: Number of patients who participated in BDP services
    - Goal: 25% of patients who participate in BDP services will report improve quality of life
    - Data Source: Achenbach System of Empirically Based Assessment (ASEBA)
- DY5:
  - I-10.1 Quality of Life

- Numerator: Percent improvement in Quality of Life
- Denominator: Number of patients who participated in BDP services
- Goal: 50% of patients who participate in BDP services will report improved quality of life
- Data Source: Achenbach System of Empirically Based Assessment (ASEBA)

Rationale

The identified process milestones and improvement targets were selected in order to measure the successful implementation and delivery of the BDP program. The Process Milestones identified above are initial procedures that establish the clinics' ability to evaluate the selected Improvement Target. The goal of the program is to decrease potential readmission to psychiatric facilities, jails and state supported facilities by offering an intensive package of services that will stabilize the individual in the home/ community setting, increase their life skills and coping strategies and improve their overall quality of life. By choosing the identified milestones and improvement targets, Metrocare will be able to systematically monitor and evaluate the effectiveness of the treatment interventions and provide immediate changes to processes for continuous quality improvement.

Outcome Measure Valuation

Metrocare Services determined the value of each project by comparing the budgeted cost of the specific project against the cost to the community should the services go unprovided. In regards to the site-based Behavioral Day Program, the significant cost of the hospitalization, emergency room visits, detainment in a correctional facility, and placement in a State Supported Living Facility were used as comparison data against cost for the Behavioral Day Program. The starting point/baseline for the program is zero, with a total census of 16 at the end of the first year. The total census of those served will increase each year by 8 individuals. It is estimated that participation in BDP will result in less than 10% returning to the ER or hospital, less than 5% involved with the criminal justice system, and less than 2% requiring placement in a State Support Living Facility in the future. We project that 25% of those that participate in DY 4 will report improved quality of life and 50% of participants in DY 5 will report improvement in quality of life.

137252607.3.9	IT-10.1	Quality of Life	
Dallas County MHMR Center dba Metrocare Services			
Related Category 1 or 2 Projects::	137252607.2.5 – Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting – Site Based Behavioral Day Program		
Starting Point/Baseline:	***Baseline is zero*** ***Target Population: Persons with developmental disabilities and mental illness that are at risk of psychiatric hospitalization, institutionalization, and/or involvement with the criminal justice system.***		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans Metric: Determine timeframe to administer Quality of Life Assessment and process for analysis of data Goal: Implement process for completing and analyzing ASEBA Data Source: Metrocare Manual of Operations; ASEBA Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 0	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process of Quality of Life Assessments (ASEBA) Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection through patient ASEBA assessments Data Source: Metrocare Manual of Operations, ASEBA, Quality Management Department Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $74,932	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process of Quality of Life Assessments (ASEBA) Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection through patient ASEBA assessments Data Source: Metrocare Manual of Operations, ASEBA, Quality Management Department Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $46,483 **Outcome Improvement Target 1** IT-10.1: Quality of Life Goal: 25% of those surveyed will report improved quality of life. Data source: ASEBA and Metrocare	**Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process of Quality of Life Assessments (ASEBA) Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection through patient ASEBA assessments Data Source: Metrocare Manual of Operations, ASEBA, Quality Management Department Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $111,001 **Outcome Improvement Target 2** IT-10.1: Quality of Life Goal: 50% of those surveyed will report improved quality of life. Data source: ASEBA and Metrocare Clinical

137252607.3.9	IT-10.1	Quality of Life	
Dallas County MHMR Center dba Metrocare Services			
Related Category 1 or 2 Projects::	137252607.2.5 – Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting – Site Based Behavioral Day Program		
Starting Point/Baseline:	***Baseline is zero*** ***Target Population: Persons with developmental disabilities and mental illness that are at risk of psychiatric hospitalization, institutionalization, and/or involvement with the criminal justice system.***		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		clinical system **Estimated Incentive Payment: $46,483**	system **Estimated Incentive Payment: $111,000**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):$0	Year 3 Estimated Outcome Amount: $ 74,932	Year 4 Estimated Outcome Amount: $92,966	Year 5 Estimated Outcome Amount: $222,001
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $389,899			

Title of Outcome Measure (Improvement Target): OD-10 Quality of Life/Functional Status

Unique RHP Outcome Identification Number: 137252607.3.12

Performing Provider name/TPI: Dallas County MHMR Center dba Metrocare Services/137252607

Outcome Measure Description:

IT 10.1 Quality of life/functional status

Process Milestones

DY 2

- P-1 Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - Metric: Determine timeframe to administer Quality of Life Assessment and process for analysis of data
    - Goal: Implement process for completing and analyzing Child and Adolescent Needs and Strengths Assessment (CANS) and Adult Needs and Strengths Assessment (ANSA)
    - Data Source: Manual of Operations, CANS/ANSA

DY 3

- P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
    - Metric: Implement PDSA cycles that monitor the data collection and analysis process of Quality of Life Assessments (CANS/ANSA)
    - Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collected through patient CANS/ANSA assessments
    - Data Source: Manual of Operations, CANS/ANSA, Quality Management Department

Outcome Improvement Targets for each year

DY 4

- IT- 10.1 Quality of Life/Functional Status
    - Numerator: Percent improvement in Quality of Life/functional status Denominator: Number of patients who were administered the survey and participated in services for, at minimum, of three consecutive months
    - Goal: 70% of patients who participate in, at minimum, three consecutive months of services, will report improved quality of life/functional status
    - Data Source: Child and Adolescent Needs and Strengths Assessment and Adult Needs and Strengths Assessment

DY 5

- IT- 10.1 Quality of Life/Functional Status
    - Metric: Demonstrate improvement in quality of life scores as measured by evidenced based and validated assessment tool (CANS/ANSA)
    - Numerator: Percent improvement in Quality of Life/functional status Denominator: Number of patients who were administered the survey and participated in services for, at minimum, of three consecutive months
    - Goal: 80% of patients who participate in, at minimum, three consecutive months of services, will report improved quality of life/functional status
    - Data Source: Child and Adolescent Needs and Strengths Assessment and Adult Needs and Strengths Assessment

Rationale:

The primary goal of this project is to expand access to behavioral health services for underserved populations. To appraise progress towards this goal, patient reported Improved Quality of Life, must be continuously evaluated using a Standardized Assessment Tool that will produce valid results. The Process Milestones identified above are initial procedures that establish the clinics' ability to evaluate the selected Improvement Target. The Child and Adolescent Needs and Strengths Assessment and the Adult Needs and Strengths Assessment were chosen as the standardized tools to measure Quality of Life as both tools have demonstrated reliability and validity and will allow Metrocare to monitor for progress towards improved quality of life throughout a client's participation in services.

Outcome Measure Valuation:

Metrocare Services determined the value of each project by comparing the budgeted cost of the specific project against the cost to the community should the services go unprovided. Costs associated with emergency room visits, hospitalization, arrest, detention and residential treatment were factors in determining the value of this project. By launching a new community based clinic in Grand Prairie, Metrocare will expand access to valuable behavioral health services and through participation in those services; clients will increase ability to improve their quality of life and functioning. It is estimated that participation in outpatient services, as defined as a minimum of three months of consecutive treatment, will result in less than 20%of those served seeking higher levels of care for psychiatric needs or involved in the criminal justice system. It is estimated that 70% of active participants (engaged in services for three consecutive months) will report improved quality of life in DY 4 and 80% will report improved quality of life in DY 5.

137252607.3.12	*IT-10.1*	*Quality of Life*	
Dallas County MHMR Center dba Metrocare Services			*TPI: 137252607*
Related Category 1 or 2 Projects:	*137252607.1.2*		
Starting Point/Baseline:	*Starting point/baseline is zero*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [*P-1]:* Project Planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric: Determine timeframe to administer Quality of Life Assessment and process for analysis of data Goal: Implement process for completing and analyzing Child and Adolescent Needs and Strengths Assessment (CANS) and Adult Needs and Strengths Assessment (ANSA) Data Source: Metrocare Manual of Operations; CANS/ANSA Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** (P-4) : Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Implement PDSA cycles that monitor the data collection and analysis process of Quality of Life Assessments (CANS/ANSA) Goal: Implement changes to data collection process and clinic intervention activities as determined necessary from Quality Improvement Reports derived from the data collection through patient CANS/ANSA assessments Data Source: Metrocare Manual of Operations, CANS/ANSA, Quality Management Department Process Milestone 2 Estimated Incentive Payment: $179,550	**Outcome Improvement Target 1** [IT-10.1 Quality of Life/Functional Status Metric: Demonstrate improvement in quality of life scores as measured by evidenced based and validated assessment tool (CANS/ANSA) Numerator: Percent improvement in Quality of Life/functional status Denominator: Number of patients who were administered the survey and participated in services for, at minimum, of three consecutive months Goal: 70% of patients who participate in, at minimum, three consecutive months of services, will report improved quality of life/functional status Data Source: CANS/ANSA Outcome improvement target 1 Estimated Incentive Payment: $181,812	**Outcome Improvement Target 2** IT-10.1 Quality of Life/Functional Status Metric: Demonstrate improvement in quality of life scores as measured by evidenced based and validated assessment tool (CANS/ANSA) Numerator: Percent improvement in Quality of Life/functional status Denominator: Number of patients who were administered the survey and participated in services for, at minimum, of three consecutive months Goal: 80% of patients who participate in, at minimum, three consecutive months of services, will report improved quality of life/functional status Data Source: CANS/ANSA Outcome improvement target 2 Estimated Incentive Payment: $367,587
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 0	Year 3 Estimated Outcome Amount: $179,550	Year 4 Estimated Outcome Amount: $181,812	Year 5 Estimated Outcome Amount: $367,587
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 728,949			

Title of Outcome Measure (Improvement Target): IT-1.10 - Diabetes Care: HbA1c Poor Control (>9.0%)

Unique RHP outcome identification number(s): 136360803.3.1

Performing Provider Name/TPI: Denton County Health & Human Services Department/ 136360803

Outcome Measure Description

IT-1.10 - Diabetes Care: HbA1c Poor Control (>9.0%) – NQF 0059 (Standalone Measure)

- **Numerator:** Number registry patients enrolled in Chronic Care Model management with HbA1c poor control.
- **Denominator:** Total number registry patients enrolled in Chronic Care Model management.

Process Milestones

- DY2:
  - Milestone 1: P-2: Establish Denton County Diabetes Registry and baseline rates
  - Milestone 1: P-1, P-2, P-3: Project Planning – engage stakeholders, identify current clients for registry, identify needed resources, determine timelines and document implementation plans
- DY3
  - Milestone 2: P-9: Program development - Initiate client and provider contacts to manage chronic care patients needing further clinical intervention.
  - Milestone 2: P-10: Conduct Plan Do Check Act cycles to improve data collection, client and provider contact, and intervention activities

Outcome Improvement Targets for each year

- DY4:
  - IT-1.10 - Diabetes Care: HbA1c Poor Control (>9.0%): reduce percentage of registry patients with poorly controlled HbA1c by 2.5% from baseline
- DY5:
  - IT-1.10 - Diabetes Care: HbA1c Poor Control (>9.0%): reduce percentage of registry patients with poorly controlled HbA1c by 2.5% from baseline

By the end of waiver in DY5 we will reduce the percentage of registry patients with poorly controlled HbA1c by 5% (combined Outcome Improvement Targets 1 and 2).

Rationale

HbA1c assesses the degree to which diabetics demonstrate blood sugar control. Greater than 9% is considered poorly controlled blood glucose levels. It is recognized as a leading cause of death and disability. Poorly controlled blood glucose levels may cause life-threatening and/or life-ending complications. This measure facilitates the prevention and long-term management of high blood sugar levels for patients with diabetes. Therefore, it was selected as the Category 3 Outcome measure for assessment. There are an estimated 60,000 diabetics in Denton County. Over 5,000 would clearly fall within the low income population that is the target of this project. The number is probably even larger since minority families have an even higher prevalence rate for diabetes. But a conservative estimate of the target population for this project is well over 5,000 low income individuals with diabetes. The identification of a diabetes management team to help diabetic patients grow in their ability to self-manage their condition would be a significant development in diabetes care for non-compliant patients, and a substantial means of reducing the long term costs associated with diabetes.

Outcome Measure Valuation

The economic value of each targeted improvement outcome was used to guide the overall value of the project. Additional value was considered for resource and labor investments, timelines, community benefit and need and project scope.

Denton County Health Department has proposed to implement the chronic care model as a means of improving patients' ability to manage their diabetes. In doing so, health outcomes will be improved, and at the same time the costs associated with their care will be substantially reduced. The most reliable diabetes data are from 2007, when a total cost of $174 billion was assigned to an estimated 25.8 million diabetics. (National Diabetes Fact Sheet, 2011) That computes to an average of $6,744 per diabetic. But those are 2007 dollars. The present project period begins in 2013 and goes to 2017. A more accurate cost per patient could be estimated at $10,000, based upon an ever increasing cost of medical care. But this estimate is for all US diabetics, most of whom have health insurance and adequate access to care.

The Denton County Health Department project addresses only Medicaid and uninsured diabetics. This specific group of clients has substantially less access to health care; they are notoriously non-compliant; and they frequently utilize hospital emergency departments in lieu of primary care providers. Their health care costs might be estimated at 2 or even 3 times higher than the average diabetic. If Medicaid and uninsured patients are estimated at double the average cost for the project period, then a cost of $20,000 per diabetic might be a reasonable projected cost.

Using this projection, the estimated costs of care for the 600 diabetic patients that are included in this proposal would be 600 x $20,000 which equates to $12,000,000. If use of the chronic

care model results in improved self-management, better patient compliance and improved health outcomes, a reduction in per person health care costs might be 50%. The resultant savings would amount to $6,000,000 which is $1 million more than the cost of the project. So the project might pay for itself, save an addition million in health care costs, and provide a model for care to Medicaid and uninsured diabetics that might result in far more substantial savings and improved health outcomes.

136360803.3.1	*3.IT-1.10*	*Diabetes Care: HbA1c Poor Control (>9.0%)*	
Denton County Health & Human Services			*TPI: 136360803*
Related Category 1 or 2 Projects:	*136360803.2.1*		
Starting Point/Baseline:	*Baseline will be established 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. Baseline: 0 Goal: Determine baseline Data Source: health care records, internal data systems. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $26,332.50 **Process Milestone 2** [*P-1*]: Project Planning – engage stakeholders, identify current clients for registry, identify needed resources, determine timelines and document implementation plans Baseline: 0 Goal: Complete project planning Data Source: Project plan or other documentation, health records, internal data systems Estimated Incentive Payment: $26,332.50	**Process Milestone 3** [P-7]: Initiate client and provider contacts to manage chronic care patients needing further clinical intervention. Baseline: 0 Goal: Complete provider contacts Data Source: Medical records, internal data systems, other documentation Process Milestone 3 Estimated Incentive Payment: $61,046 **Process Milestone 3** [P- 4]: Conduct Plan Do Check Act cycles to improve data collection, client and provider contact, and intervention activities Baseline: 0 Goal: PDCA analyses Data Source: Internal data systems Estimated Incentive Payment*:* $61,046	**Outcome Improvement Target 1** [IT-10]: HbA1c Poor Control (>9.0%) Improvement Target: Reduce percentage of registry patients with poorly controlled HBA1c by 2.5% from baseline Baseline: 0 Goal: 2.5% reduction in number of patients with poorly controlled HBA1c Data Source: Medical records, internal data systems, other documentation Estimated Incentive Payment*:* $130,610	**Outcome Improvement Target 2** [IT-10]: HbA1c Poor Control (>9.0%) Improvement Target: Reduce percentage of registry patients with poorly controlled HBA1c by additional 2.5% from baseline Baseline: 0 Goal: ~~additional 2.5%~~ 5% reduction in number of patients with poorly controlled HBA1c Data Source: Medical records, internal data systems, other documentation Estimated Incentive Payment*:* $283,935
Year 2 Estimated Outcome Amount: $ 52,665	Year 3 Estimated Outcome Amount: $ 122,092	Year 4 Estimated Outcome Amount: $ 130,610	Year 5 Estimated Outcome Amount: $ 283,935
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $589,302			

Title of Outcome Measure (Improvement Target): IT-2.10 - Flu and pneumonia Admission Rate

Unique RHP outcome identification number(s): 136360803.3.2

Performing Provider Name/TPI: Denton County Health & Human Services Department/ 136360803

Outcome Measure Description

OD-2: Potentially Preventable Admissions

- IT-2.10 Flu and Pneumonia Admission Rate
    - **Numerator:** Number admissions among low income adult clinic clients with pneumonia or flu
    - **Denominator:** Total number low income adult clients served by Denton County Health clinics.

Process Milestones

- DY2
    - Milestone 1: P-1: Project Planning – purchase vaccine, engage stakeholders, identify current clients for immunization, identify needed resources, determine timelines and document implementation plans
    - Milestone 2: P-2: Establish baseline clients needing vaccination and administer vaccines
- DY3
    - Milestone 3: P-7: Initiate client and provider contacts and participate in learning meetings and seminars.
    - Milestone 4: P-10: Conduct performance improvement activities modeled after the Plan, Do, Check, Act (PDCA) improvement cycle process and "lessons learned" models

Outcome Improvement Targets for each year

- DY4:
    - IT-2.10: Flu and Pneumonia Admission Rate: Reduce percentage of clinic clients hospitalized with pneumonia or flu by additional 2.5% from baseline.
- DY5:
    - IT-2.10: Flu and Pneumonia Admission Rate: Reduce percentage of clinic clients hospitalized with pneumonia or flu by additional 2.5% from baseline.

By the end of waiver in DY5 we will reduce clinic client admission rates for vaccine preventable pneumonia or influenza by 5% (combined Outcome Improvement Targets 1 and 2).

Rationale

Expanded use of adult immunizations can prevent disease and substantially reduce health care costs by reducing hospitalizations. The health impact of flu and pneumonia is substantial; therefore, hospital admission rates for pneumonia or influenza was selected as the Category 3 Outcome measure for assessment. Vaccines are the most effective way to prevent severe illness and complications. Every year vaccine preventable diseases in adults account for millions of dollars in health care expenditures. Between 2005 and 2010, there were 5,895 hospital admissions in Denton County for bacterial pneumonia. The cumulative cost of just these hospital admissions was over $230 million dollars. Pneumonia vaccine can prevent a large percentage of these hospitalizations which collectively cost essentially $486 for every adult in Denton County.

Outcome Measure Valuation

The economic value of each targeted improvement outcome was used to guide the overall value of the project. Additional value was considered for resource and labor investments, timelines, community benefit and need and project scope.

Denton County has proposed to improve health outcomes for Medicaid and uninsured residents by expanding adult immunizations. The rationale for the use of vaccines to reduce health care costs is perhaps the best success story in public health. The cost reduction in the treatment of smallpox is quite dramatic. Similarly, health care expenditures for polio have been all but eliminated as a direct result of the use of vaccines. DCHD outcomes for influenza and bacterial pneumonia immunization may not be quite as spectacular, but they are predictable and substantial.

Texas Department of State Health Services documents confirm 5,895 hospitalizations from 2005 to 2010 for bacterial pneumonia. The total hospital charges that resulted from these admissions was $233,417,472, an average of $39,596 per hospitalization. The DCHD proposal includes the vaccination of 1500 Medicaid recipients and uninsured residents for bacterial pneumonia. If these immunizations result in the prevention of 100 hospitalizations, the associated savings would be $3,959,600.

Similarly, influenza hospitalization costs would also reduced. Although influenza costs for hospitalization are not as great, there are more of them. A conservative cost estimate is $10,000 per influenza admission. Consequently, if the provision of 1500 doses of vaccine were to result in 100 fewer hospitalizations, the resultant savings would be about $1,000,000. Keep

in mind the 1500 vaccinations would mean 1500 fewer individuals to spread influenza to other susceptibles, so 100 fewer hospitalizations is not a stretch.

These are only the hospitalization costs and do not take into consideration the costs related to health care providers, labs, pharmacy, etc. Furthermore, this is only two of the proposed 10 vaccines. These two vaccines alone could result in hospitalization savings of 4.9 million. Additional savings realized from pertussis, hepatitis A, hepatitis B, Zoster, and the other vaccines would surely result in savings of at least $1,000,000. That would bring the hospitalization savings to 5.9 million and another million could be anticipated in provider, laboratory, and pharmacy savings. So the total estimated savings would exceed 6.9 million from a program that costs only 5 million. Given the documented cost effectiveness of vaccine programs, this initiative to improve adult immunizations among Medicaid recipients and the uninsured is clearly cost effective.

136360803.3.2	*3.IT-2.10*	*Flu and pneumonia Admission Rate*	
Denton County Health & Human Services			*TPI: 136360803*
Related Category 1 or 2 Projects:	*136360803.2.2*		
Starting Point/Baseline:	*Baseline will be established 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)**
Milestone 1 [*P-1*]: Project Planning – purchase vaccine, engage stakeholders, identify current clients for immunization, identify needed resources, determine timelines/document implementation plan Baseline: 0 Goal: Complete project planning Data Source: Project plan or other documentation, health records, internal data systems. Process Milestone 1 Estimated Incentive Payment: $26,333 **Milestone 2** [P-2]: Establish baseline - clients needing vaccination & administer vaccines Baseline: 0 Goal: Determine baseline Data Source: health care records, internal data systems. Process Milestone 2 Estimated Incentive Payment*:* $26,333	**Milestone 3 [P-7]:** Initiate client and provider contacts and participate in learning meetings and seminars. Baseline: 0 Goal: Complete provider contacts Data Source: Program documentation Process Milestone 3 Estimated Incentive Payment: $61,046 **Milestone 4 [P-4]**: Conduct Plan Do Check Act cycles to improve data collection, client and provider contact, and intervention activities Baseline: 0 Goal: Complete PDCA analyses Data Source: Internal data systems Process Milestone 4 Estimated Incentive Payment*:* $61,046	**Outcome Improvement Target 1** [IT-2.11]: Flu and pneumonia Admission Rate Improvement Target: Reduce percentage of clinic clients hospitalized with pneumonia or flu by 2.5% from baseline. Baseline: 0 Goal: 2.5% reduction in number of clinic clients hospitalized with pneumonia or flu from baseline. Data Source: Medical records, internal data systems Outcome Improvement Target 1 Estimated Incentive Payment*:* $130,610	**Outcome Improvement Target 2** [IT-2.11]: Flu and pneumonia Admission Rate Improvement Target: Reduce percentage of clinic clients hospitalized with pneumonia or flu by additional 2.5% from baseline. Baseline: 0 Goal: 5% reduction in number of clinic clients hospitalized with pneumonia or flu from baseline. Data Source: Medical records, internal data systems Outcome Improvement Target 2 Estimated Incentive Payment*:* $283,935
Year 2 Estimated Outcome Amount: $ 52,666	Year 3 Estimated Outcome Amount: $ 122,092	Year 4 Estimated Outcome Amount: $ 130,610	Year 5 Estimated Outcome Amount: $ 283,935
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $589,303			

Title of Outcome Measure (Improvement Target): IT-9.2: ED Appropriate Utilization

Unique RHP Outcomes Identification Number: 135234606.3.1

Performing Provider Name/TPI: Denton County MHMR Center/135234606

Outcome Measure Description

OD-9: Right Care, Right Setting

- IT-9.2: ED Appropriate Utilization (Stand-alone Measure)

Establish a 24 hour psychiatric triage facility to increase the capacity to provide psychiatric services, to better accommodate the high demand for triage services, and to reduce inappropriate emergency room usage. The project goals include the development of a 24 hour psychiatric triage facility that will link individuals in need of psychiatric services with appropriate care. The community need for this project is due to: lack of funding, lack of a public hospital, lack of voluntary and involuntary beds at state mental health facilities, lack of additional community resources to promote preventative behavioral health services. The county lacks community resources for behavioral health care assessment/services for indigent individuals outside of the Local Mental Health Authority. The United Way of Denton County, Inc. identified health needs and mental health services for depression as top findings in the assessment [CN.5]. The lack of health care access is attributed to a lack of insurance (2011: 17.2% adults and 10.6% children in Denton County, [CN.5]. The starting point for expansion and enhancement of behavioral health service availability is by developing 24 hour psychiatric triage services. Services include assessment, medication management and referral as indicated, to a higher level of care. The four year expected outcome of the project is to provide expanded behavioral health triage services through a centralized location, thus reducing potentially preventable admissions/readmissions to area hospitals and emergency rooms.

Rationale

The rationale for the project is in the value of reducing ED admit/readmit rates and prevention of unnecessary ED, acute care, and criminal justice use [6]. This initiative will also enhance the opportunity for additional jail diversion [6, CN.7]. When individuals that have a mental health diagnosis receive treatment and are able to return to work the value to the community is increased by wages and taxable income [8, 4, 10]. Individuals that have a mental health diagnosis earn $16,000 less annually than their non-diagnosed counterpart. This costs employers in the United States and other countries, including Australia, billions in dollars in lost revenue generation, and loss of labor force. Millions of dollars are also lost in income tax revenue. The Texas economy loses $5 billion annually due to mental illness mostly through loss of worker production [6, 11, 9, 13]. Effective community triage, referrals, and community treatment can reduce emergency room admission and readmission, acute care, as well as

decrease lost revenue and increase expenditure on avoidable incarceration. The cost of care for a person that has a mental illness is as follows, incarceration $137 per day, ER $1265 per visit, state mental health hospital $400 per day; verses community cost of care for a person that has a mental illness: $12.00 per day. Appropriate triage can prevent incarceration, ER visits, acute care utilizations, and state hospital admits by appropriate referrals to the community mental health system [5]. Moreover, in an Integrated Care Collaboration model study, it was noted that nine frequent ER users over six years cost three million dollars to treat, and seven of those nine had a mental illness [1, 2, 3, 4, 7, 12].

Outcome Measure Valuation

The value of the project will be measured by amount of individuals served in the psych triage facility being provided the right care in the right setting. The value for the project is reducing Emergency Department (ED) admit/readmit rates and prevention of unnecessary ED, acute care, and criminal justice use [6]. This initiative will also enhance the opportunity for additional jail diversion [6]. When individuals that have a mental health diagnosis receive treatment and are able to return to work the value to the community is increased by wages and taxable income [8, 4, 10]. Individuals that have a mental health diagnosis earn $16,000 less annually than their non-diagnosed counterpart This costs employers in the United States and other countries, including Australia, billions of dollars in lost revenue generation, and loss of labor force. Millions of dollars are also lost in income tax revenue. The Texas economy loses $5 billion annually due to mental illness mostly through loss of worker production [6, 11, 9, 13]. Effective community triage, referrals, and community treatment can reduce emergency room admission and readmission, acute care, as well as decreasing lost revenue and increased expenditure on avoidable incarceration. The cost of care for a person that has a mental illness is as follows: Incarceration $137 per day, ER $1265 per visit, state mental health hospital $400 per day, and community cost of care for a person that has a mental illness is $12 per day. Appropriate triage can prevent incarceration, ER visits, acute care utilizations, and state hospital admits by appropriate referrals to the community mental health system [5]. Moreover, in an Integrated Care Collaboration model, it was noted that nine frequent ER users over six years cost three million dollars to treat and seven of those nine had a mental illness [1, 2, 3, 4, 7, 12]. In addition, through econometrics, we value the impact of this project to the community at $30,000,000 although Denton County MHMR Center is requesting a much smaller DSRIP valuation/incentive payment for this project.

135234606.3.1	*3.IT-9.2*	*Right Care, Right Setting: ED Appropriate Utilization*	
Denton County MHMR Center			*135234606*
Related Category 1 or 2 Projects:	*135234606.2.1*		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1[P-1]: Project planning-engage stakeholders, identify current capacity and needed resources, determine timeline and document implementation plans. Metric 1 [P1.1]: Number of meetings held, stakeholders engaged and resources secured. Data Source: Performing provider documentation. Baseline/Goal: 2 meetings during Dy 2 Milestone 1 Estimated Incentive Payment: *$26,053*	Milestone 2[P-2] Establish baseline rates. Metric 2 [P-2.1]: Research to determine the baseline rates of inappropriate ED usage for behavioral health patients. Data Source: Performing provider documentation. Baseline/Goal: Research and analyze assessments from 2011 and 2012 to determine number of individuals inappropriately referred to ED for psychiatric treatment. Milestone 2 Estimated Incentive Payment: *$261,287*	Milestone 3[IT -9.2]: ED appropriate utilization. Reduce Behavioral health ED visits. Metric 3 [IT-9.2]: Reduce inappropriate behavioral health ED usage. Data Source: Performing provider documentation (crisis documentation). Baseline/Goal: Reduce inappropriate behavioral ED usage by 15% over baseline. Milestone 3 Estimated Incentive Payment: *$325,287*	Milestone 4[IT -9.2]: ED appropriate utilization. Reduce all behavioral health ED visits. Metric 4 [IT-9.2]: Reduce inappropriate behavioral health ED. Data Source: Performing provider documentation (crisis documentation). Baseline/Goal: Reduce inappropriate behavioral ED usage by 30% over baseline. Milestone 4 Estimated Incentive Payment: *$650,574*
Year 2 Estimated Outcome Amount: $26,053	Year 3 Estimated Outcome Amount: $261,287	Year 4 Estimated Outcome Amount: $325,287	Year 5 Estimated Outcome Amount: $650,574
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 1,263,201			

Title of Outcome Measure (Improvement Target): IT-6.1 Patient Satisfaction

Unique RHP Outcomes Identification Number: 135234606.3.2

Performing Provider Name/TPI: Denton County MHMR Center/135234606

Outcome Measure Description

OD-6: Patient Satisfaction

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

Patient satisfaction through integrating behavioral and primary health will reduce inappropriate ED usage for those clients with co-morbid diseases. Design, implement, and evaluate projects that provide integrated primary and behavioral health care services. The goal for the project includes the integration of care management functions for individuals with co-morbid chronic diseases, mental illness, and/or substance use disorders, by collaborative partnership agreements for delivery of primary and behavioral health care management. The challenges and issues of the performing provider include; limited funding opportunities for expansion, extensive waitlist of behavioral health services, currently over-serving Department of State Health Services (DSHS) funding capacity to fulfill the needs for behavioral health services (Adults 113%, children and adolescents 197%), and lack of community resources for provision of primary care and co-morbid chronic diseases. The implementation of this project will reduce the extensive wait list for Denton County MHMR Center (over 300 clients as of October 2012), provide access health care for uninsured and underinsured clients, and reduce ED costs by providing improved access. In addition, Denton County does not have a public acute-care safety net hospital. According to 2011 census, Denton County has a poverty level of 8.9%. According to 2011 United Way of Denton County, Inc. needs assessment, 17.2% of adults and 10.6% of children in Denton County are uninsured [CN.5].

Rationale

The rationale for the project is the value to the community, public health system, criminal justice system, and hospitals by reducing inappropriate emergency room admissions, readmissions, and inappropriate use of the criminal justice system. The project will address core components A, B, C, D, E, F, G, H, I, and J of 2.15.1 of the RHP planning protocol. If integrated and primary behavioral health care access is not available, the indigent population is often forced to turn to expensive sites of care such as EDs and urgent care. The United Way of Denton County, Inc. Needs Assessment further identified affordable and accessible health care and preventative health care as needs in Denton County [CN.6]. Various research has shown that integrated health care can save billions yearly, by avoiding emergency room visits and incarceration. An example of cost savings is using community based care at the average of $12 a day, compared with the cost of $1265 for a limited emergency room visit. According to the

National Association of Community Mental Health Centers Inc. as cited in article [6], 35% of emergency room visits are avoidable if access to primary care exists, leading to savings of $18 billion per year. This study cites Texas as one of four states that spends over 1 billion annually on ED visits [6]. A different example of the cost effectiveness of integrated health care includes a pilot integrated health care system in Colorado, where a $2040 savings per year per patient occurred. A total of 200 served over five years equaled $408,000 saved over regular care [3]. In a project report, it is listed that the effect of an integrated intervention is equivalent to an increase of 0.338 quality-adjusted life-years [2]. Twenty individuals served x 0.338 x $50,000 (life year value) = $338,000 savings. Collaborative care models have shown savings of $1.7 for every dollar invested. Integrated primary and behavioral health care has shown to improve the quality of care, cost effectiveness, and decreases the disparities in health care [1, 3, 6, 7, 8, 9, 10, 11]. In addition, through econometrics, we value the impact of this project to the community at $15,000,000, although Denton County MHMR Center is requesting a much smaller DSRIP valuation/incentive payment for this project.

Outcome Measure Valuation

The value of the project will be measured by the number of individuals served in the integrated health clinic. The value of the project is reducing ED admit/readmit rates and prevention of unnecessary ED, acute care, and criminal justice use [6]. The value for the project to the community, public health system, criminal justice system, and hospitals is reducing inappropriate emergency room admissions, readmissions, and inappropriate use of the criminal justice system. If integrated and primary behavioral health care access is not available, the indigent population is often forced to turn to expensive sites of care such as EDs and urgent care. Various research shows that integrated health care can save billions yearly by avoiding emergency room visits and incarceration. The cost of care for a person that has a mental illness is as follows: incarceration $137 per day, ER $1265 per visit, state mental health hospital $400 per day, and community cost of care for a person that has a mental illness is $12 per day. According to the National Association of Community Mental Health Centers Inc. as cited in article [6], 35% of emergency room visits are avoidable if access to primary care exists, leading to savings of $18 billion per year. This study cites Texas as 1 of 4 states that spends over 1 billion annually [6]. A different example of the cost effectiveness of integrated health care includes a pilot integrated health care system in Colorado, where a $2040 saving per year per patient occurred. A total of 200 served over 5 years equal $408,000 saved over regular care [3]. In a project report [2], it is listed that the effect of an integrated intervention is equivalent to an increase of 0.338 quality-adjusted life-years. Twenty individuals served x 0.338 x $50,000 (life year value) = $338,000 savings. Collaborative care models have shown savings of $1.7 dollars for every dollar invested. Integrated primary and behavioral health care has shown to improve the quality of care, cost effectiveness, and decreases the disparities in health care [1, 3, 4, 6, 7, 8, 9, 10, 11, 12].

In addition, through econometrics, we value the impact of this project to the community at $15,000,000, although Denton County MHMR is requesting a much smaller DSRIP valuation/incentive payment for this project.

135234606.3.2	*3 IT.6.1*	*Patient Satisfaction: Percentage improvement over baseline*	
Denton County MHMR Center			*135234606*
Related Category 1 or 2 Projects:	*135234606.2.2*		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Project planning, engage stakeholders, identify current capacity, and needed resources, determine timeline, and document implementation plans, Metric 1 [P-2.1]: Number of patients in various areas who might benefit from integrated services. Demographics, location, and diagnoses. Data Source: Performing provider documentation Baseline/Goal: 2 meetings during the year. Milestone 1 Estimated Incentive Payment: *$14,190*	Process Milestone 2 [P-3]: Develop and test data systems Metric 2 [P-3.1]: Develop and test data systems through meetings and trainings to maximize information sharing and referral processes. Data Source: Performing Provider Documenation Baseline/Goal: Quarterly meetings to discuss barriers and progress Milestone 2 Estimated Incentive Payment: *$140,556*	Process Milestone 3 [IT 6-1]: Percent improvement over baseline of patient satisfaction scores. Satisfaction surveys measure the client's perception of services rendered. Metric 3 [IT 6-1]: Satisfaction surveys measure the client's perception of services rendered. Data Source: Satisfaction Survey Baseline/Goal: 50 % improvement over baseline of patient satisfaction scores. Milestone 3 Estimated Incentive Payment: *$155,557*	Process Milestone 4 [IT 6-1]: Percent improvement over baseline of patient satisfaction scores. Satisfaction surveys measure the client's perception of services rendered. Metric 4 [IT 6-1]: Satisfaction surveys measure the client's perception of services rendered. Data Source: Satisfaction Survey Baseline/Goal: 75% over improvement over baseline of patient satisfaction scores. Milestone 4 Estimated Incentive Payment: *$360,113*
Year 2 Estimated Outcome Amount: $14,190	Year 3 Estimated Outcome Amount: $140,556	Year 4 Estimated Outcome Amount: $155,557	Year 5 Estimated Outcome Amount: $360,113
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $670,416			

Title of Outcome Measure (Improvement Targets): IT-6.1: Patient Satisfaction

Unique RHP Outcome Identification Number: 135234606.3.3

Performing Provider Name/TPI: Denton County MHMR Center/135234606

Outcome Measure Description

OD6: Patient Satisfaction

Patient Satisfaction through providing specialty services to individuals in Denton County through a crisis residential care program. Establish crisis residential program to provide an intervention for a target behavioral health population to prevent unnecessary use of services in a specified setting. Increase the capacity to provide crisis residential services to better accommodate the high demand for crisis residential services and reduce potentially preventable admissions and readmissions. The goal for this project is to reduce the demand for inappropriate admissions (i.e., the criminal justice system, ER, urgent care) and assist the individual in maintaining residence in the community. The community need for the project is due to readmissions for inpatient care. The challenges and issues of the performing provider include: funding for project, lack of community resources for crisis residential services, and the lack of a public acute-care safety net hospital in Denton County. According to the 2011 United Way Survey, emergency transitional housing and shelter needs have continued to rise in Denton County [CN.5]. The Section 8 Denton Housing Authority (DHA) list closed in June of 2011. The DHA currently has a waitlist of 2,700 individuals; the estimated wait for assistance is four years. The starting point would be the development of a crisis residential home with a capacity of 8 individuals with additional beds for additional needs, such as individuals with substance abuse disorders, transition from criminal justice system, and transition from a higher level of need. The four year expected outcome of the project is to provide short-term community based residential crisis treatment for individuals in Denton County.

Rationale

The rationale for this project is to improve outcomes and promote access to quality behavioral health care services on a regular basis. The project has been identified as a need in Denton County in the United Way Needs Assessment Survey [10,CN.5]. Emergency shelter and transitional housing have been included in the top four needs in the income section of this community needs assessment [10, 11, CN.5]. Individuals that have a mental health diagnosis and are in need of housing services often turn to the emergency rooms as first line treatment for their mental illness and housing needs. This treatment center will provide emergency and transitional housing and shelter using the Department of State Health Services crisis residential staffing guidelines. Qualified mental health professionals will be available. The combination of these services will reduce behavioral and medical emergency room admission and readmission, as well as decrease lost revenue and increase expenditure on avoidable incarceration. Acute

treatment costs were 44% lower in a crisis residential program ($3046 per episode) as compared to hospitalization ($5,549 per episode) and the typical cost for homeless persons is $2,897 per month [1]. The typical cost of housing for residents in supportive housing is $605 per month. This is a savings of $2,292 per month for one individual [2, 3, 4, 5, 6, 7, 8, 9]. In addition, through econometrics, we value the impact of this project to the community at $15,000,000, although Denton County MHMR is requesting a much smaller DSRIP valuation/incentive payment for this project.

Outcome Measure Valuation

Patient satisfaction will be determined by assessment of several areas including**:** the value for the project to the community, public health system, criminal justice system, and hospitals by reducing inappropriate emergency room admissions, readmissions, and inappropriate use of the criminal justice system. If integrated and primary behavioral health care access is not available, the indigent population is often forced to turn to expensive sites of care such as EDs and urgent care. Research shows that integrated health care can save billions yearly, by avoiding emergency room visits and incarceration. The cost of care for a person that has a mental illness is as follows: Incarceration $137 per day, ER $1265 per visit, state mental health hospital $400 per day, and community cost of care for a person that has a mental illness: $12.00 per day. According to the National Association of Community Mental Health Centers Inc. as cited in article [6], 35% of emergency room visits are avoidable if access to primary care exists, leading to savings of 18 billion dollars a year. This study cites Texas as one of four states that spends over 1 billion annually [6]. A different example of the cost effectiveness of integrated health care includes a pilot integrated health care system in Colorado, where a $2040 savings per year per patient occurred. A total of 200 served over five years equaled $408,000 saved over regular care [3]. In a project report [2], it is listed that the effect of an integrated intervention is equivalent to an increase of 0.338 quality-adjusted life-years. Twenty individuals served x 0.338 x $50,000 (life year value) = $338,000 savings. Collaborative care models have shown savings of $1.7 for every dollar invested. Integrated primary and behavioral health care has shown to improve the quality of care, cost effectiveness, and decreases the disparities in health care [1, 3, 4, 6, 7, 8, 9, 10, 11, 12].

135234606.3.3	*3 IT.6.1*	*Patient Satisfaction: Percentage improvement over baseline*	
Denton County MHMR Center			*135234606*
Related Category 1 or 2 Projects:	*135234606.2.3*		
Starting Point/Baseline:	*To be determined in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1[P-1]: Project planning-engage stakeholders, identify current capacity and needed resources, determine timeline and document implementation plans. Data Source: Performing provider documentation Metric 1 [P-1.1]: Number of patients in various areas who might benefit from integrated services. Demographics, location, and diagnoses. Data Source: Meeting minutes. Baseline/Goal: 2 meetings during the year. Milestone 1 Estimated Incentive Payment: *$22,276*	Milestone 2[P -1]: Project planning-engage stakeholders, identify current capacity and needed resources, determine timeline and document implementation plans. Data Source: Performing provider documentation Metric 2 [P-1.1]: Number of patients in various areas who might benefit from integrated services. Demographics, location, and diagnoses. Data Source: meeting minutes Baseline/Goal: 2 meetings during the year Milestone 2 Estimated Incentive Payment: *$295,760*	Milestone 3 [IT -6.1] Percent improvement over baseline of patient satisfaction scores. Metric 3 [IT 6-1]: Satisfaction surveys measure the client's perception of services rendered. Data Source: Satisfaction Survey Baseline/Goal: 50 % improvement over baseline of patient satisfaction scores. Milestone 3 Estimated Incentive Payment: *$253,760*	Milestone 4 [IT -6.1] Percent improvement over baseline of patient satisfaction scores. Metric 4 [IT 6-1]: Satisfaction surveys measure the client's perception of services rendered. Data Source: Satisfaction Survey Baseline/Goal: 75% over improvement over baseline of patient satisfaction scores. Milestone 4 Estimated Incentive Payment: *$590,815*
Year 2 Estimated Outcome Amount: $22,276	Year 3 Estimated Outcome Amount: $295,760	Year 4 Estimated Outcome Amount: $253,760	Year 5 Estimated Outcome Amount: $590,815
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 1,162,611			

Title of Outcome Measure (Improvement Target): IT-4.8 Sepsis mortality

Unique RHP outcome identification number(s): 111905902.3.1

Performing Provider Name/TPI: Denton Regional Medical Center/111905902

Outcome Measure Description

IT-4.8 Sepsis mortality is the percentage of those patients diagnosed with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction that expire during hospitalization. Mortality rates are very high in US from sepsis. With earlier diagnosis of sepsis and compliance with Sepsis Resuscitation and Management Bundles we will decrease the mortality rate. We expect to diagnose and treat 530 sepsis patients (estimated at DY 1- 55, DY2-83, DY 3- 103, DY 4- 129, DY 5-160).

Process Milestones

In DY 2 we will establish baseline rates for sepsis mortality to measure for improvement targets. In DY2 and 3 we will conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.
It is expected that the morality rate for this population in DY 2 will initially increase compared to DY 1 due to more patients being correctly diagnosed with new sepsis protocols thus a baseline will be established in DY2 to measure same mortality rates based on same standards of care.

Outcome Improvement Targets

By DY 4 and DY5, the improvement target is Sepsis mortality reduction of 25% by the end of the waiver.

Rationale

The process milestone to establish a baseline rate is necessary to understand the starting point for sepsis mortality as defined by protocl in order to measure improvement in DY 4 and DY 5.

The process milestone selected for conducting Plan Do Study Act (PDSA) will implement a continuous quality improvement model consisting of a logical sequence of four repetitive steps for continuous improvement and learning that will assist in the achievement of improvement targets. By turning ideas into action and connecting action to learning we believe PDSA cycles will facilitate change. The process that can be analyzed and measured with data and compared to predicted results will expedite new changes to be implemented in a disciplined fashion in as necessary repetitive cycle.

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. The outcome target for mortality was selected as evidence based initiatives put in place can reduce mortality. In order to measure the effectiveness of sepsis initiatives mortality rate reduction will be measured.. Each year mortality from severe sepsis and septic shock nationally have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Outcome Measure Valuation

The economic value of each targeted improvement outcome from evidence based studies was used a guide for the overall value of project. Additional value was considered for resource investments needed, timelines, cost avoidance, community benefit and risk and project scope.

Denton Regional Medical Center defined the population that will be directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The population expected to be positively impacted by the project for mortality was 531 which was determined based on outcome target for reduction in mortality by 25% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 25. The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $258,375 for 5 years.
The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay of 2 days from baseline average of 10 days per patient. This was estimated at total of reduced in patient days by DY 5 of 704. The estimated current ALOS is based on coded claims and not entire population that will be diagnosed and treated in the future as this in the only information available at the time of project. But reasonableness estimates this is within target of sample cases in baseline year. The estimated cost per day for a sepsis patient is $1,049. This totaled approximately $739,230.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $258,375.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 1. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $110,885.

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this

to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of mortality reduction at $258,375.
To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $107,551.

The total value of the project then was estimated at $1,732,791. Approximately 79% of the total value was assigned to Category 2 project ($1,370,117) and the remaining 10.46% of value assigned to Category 3 outcome for Sepsis Mortality ($181,338) and 10.46% assigned to Category 3 outcome for reduced Average Length of Stay ($181,336).

111905902.3.1	*3.IT-4.8*	*Sepsis mortality*	
Denton Regional Medical Center			*111905902*
Related Category 1 or 2 Projects::	*111905902.2.1*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients hospitalized with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.* *Target population: patients hospitalized with severe sepsis or septic shock and/or an infection and organ dysfunction.*		
Year 2 (10/1/2012 – 9/30/2013)	**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 <u>Metric 1:</u> Number of patients treated with Sepsis Resuscitation and Management Bundles Goal: Baseline Data Source: EHR Process Milestone 1 Estimated Incentive*:* $10,023 **Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities <u>Metric 1:</u> : Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Initiative Plan Process Milestone 2 Estimated Incentive Payment*:* $10,022	**Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities <u>Metric 1:</u> : Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Initiative Plan Process Milestone 3 Estimated Incentive Payment: $34,853	**Outcome Improvement Target 1** [IT-4.8]: Improvement Target: 15% reduction in mortality Data Source: Outcome Improvement Target 1 Estimated Incentive Payment*:* $37,284	**Outcome Improvement Target 2** [IT-4.8]: Improvement Target: 25% reduction in mortality from base line Data Source: Outcome Improvement Target 2 Estimated Incentive Payment*:* $89,156
Year 2 Estimated Outcome Amount: $20,045	Year 3 Estimated Outcome Amount: $34,853	Year 4 Estimated Outcome Amount: $37,284	Year 5 Estimated Outcome Amount: $89,156
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $181,338			

Title of Outcome Measure (Improvement Target): IT-4.9 Average length of stay

Unique RHP outcome identification number(s): 111905902.3.2

Performing Provider Name /TPI: Denton Regional Medical Center/111905902

Outcome Measure Description

IT- 4.9: Average length of stay is the number days a patient is hospitalized when diagnosed with severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl). With earlier diagnosis of sepsis and compliance with Sepsis Resuscitation and Management of care, average length stay should decrease as result. We expect to diagnose and treat 530 sepsis patients (estimated at DY 1- 55, DY2-83, DY 3- 103, DY 4- 129, DY 5-160).

Process Milestones

In DY 2 we will establish baseline rates for sepsis average length of stay to measure for improvement targets. IN DY2 and 3 we will conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.
It is expected that the average length of stay for this population in DY 2 will initially be different compared to DY 1 due to more patients being correctly diagnosed with new sepsis protocols thus a baseline will be established in DY2 to measure length of stay based on same standards of care.

Outcome Improvement Targets

By DY 4 and DY5, the improvement target is Sepsis average length of stay of 20% by the end of the waiver.

Rationale

The process milestone to establish a baseline rate is necessary to understand the starting point for the average length of stay for patient receiving Sepsis Resuscitation Management Bundle Care in order to measure improvement in DY 4 and DY 5. Typically average length of stay for ICU has been measure but not for the entire hospitalization.

The process milestone selected for conducting Plan Do Study Act (PDSA) will implement a continuous quality improvement model consisting of a logical sequence of four repetitive steps for continuous improvement and learning that will assist in the achievement of improvement targets. By turning ideas into action and connecting action to learning we believe PDSA cycles will facilitate change. The process that can be analyzed and measured with data and compared to predicted results will expedite new changes to be implemented in a disciplined fashion in as necessary repetitive cycle.

The outcome improvement target to reduce length of stay was selected to measure the effectiveness of evidence based care initiatives for sepsis diagnosis and treatment. Average length of stay reduction can also show advancement of sepsis care that is effective through the continuum of the hospital not just in critical care units and comprehensive, coordinated discharge planning.

Outcome Measure Valuation

The economic value of each targeted improvement outcome from evidence based studies was used a guide for the overall value of project. Additional value was considered for resource investments needed, timelines, cost avoidance, community benefit and risk and project scope of the project.

Denton Regional Medical Center defined the population that will be directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The population expected to be positively impacted by the project for mortality was 531 which was determined based on outcome target for reduction in mortality by 25% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 25. The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $258,375 for 5 years.
The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay of 2 days from baseline average of 10 days per patient. This was estimated at total of reduced in patient days by DY 5 of 704. The estimated cost per day for a sepsis patient is $1,049. This totaled approximately $739,230.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $258,375.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 1. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $110,885.

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of mortality reduction at $258,375.

To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $107,551.

The total value of the project then was estimated at $1,732,791. Approximately 79% of the total value was assigned to Category 2 project ($1,370,117)and the remaining 10.46% of value assigned to Category 3 outcome for Sepsis Mortality ($181,338) and 10.46% assigned to Category 3 outcome for reduced Average Length of Stay ($181,336).

111905902.3.2	*3.IT-4.9*	*Average length of stay (Non-standalone measure)*	
	Denton Regional Medical Center		*111905902*
Related Category 1 or 2 Projects:	*111905902.2.1*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients hospitalized with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.* *Target population: patients hospitalized with severe sepsis or septic shock and/or an infection and organ dysfunction.*		
Year 2 (10/1/2012 – 9/30/2013)	**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 Metric 1: ALOS for patients treated with Sepsis Resuscitation and Management Bundles Goal: establish and define baseline Data Source: EHR Process Milestone 1 Estimated Incentive Payment :$10,023 **Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Improvement Plan Process Milestone 2 Estimated Incentive Payment: $10,022	**Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Improvement Plan Process Milestone 3 Estimated Incentive Payment: $34,852	**Outcome Improvement Target 1** [IT-4.9]: Improvement Target: 10% reduction from baseline average length of stay Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $37,282	**Outcome Improvement Target 2** [IT-4.9]: Improvement Target: 20% reduction from baseline average length of stay Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $89,157

111905902.3.2	*3.IT-4.9*	*Average length of stay (Non-standalone measure)*	
	Denton Regional Medical Center		*111905902*
Related Category 1 or 2 Projects:	*111905902.2.1*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients hospitalized with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.* *Target population: patients hospitalized with severe sepsis or septic shock and/or an infection and organ dysfunction.*		
Year 2 (10/1/2012 – 9/30/2013)	**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: $20,045	Year 3 Estimated Outcome Amount: $34,852	Year 4 Estimated Outcome Amount: $37,282	Year 5 Estimated Outcome Amount: $89,157
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $181,336			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent Improvement over baseline of patient satisfaction scores

Unique RHP outcome identification number(s):111905902.3.3

Performing Provider Name/TPI: Denton Regional Medical Center/111905902

Outcome Measure Description:

IT-6.1 Percent Improvement over baseline of patient satisfaction scores. At the end of the 5 year waiver, scores will be improved by 20%. Approximately 33% of our patients are either Medicaid eligible or indigent. We estimate 10,200 patients a year or 54,000 over the course of the waiver will be impacted. We do actively survey 100 patients a month/1200 a year

Process Milestone:
DY 2 we will establish baseline data to measure for patient satisfaction scores. In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. It will also be necessary establish a base line rate in order to correctly measure the improvement target. In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders.

Outcome Improvement targets for each year:
The target for the outcome measure is 10% improvement in scores over baseline in DY 4 and 20% in DY 5 over baseline.

Rationale:
. The outcome improvement targets were selected as they are congruent with other goals of the organization and will result in improved health outcome of patients and reduce cost to the health system.

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders (IP /OP, out of hospital providers, etc) are identified and included in the plan. Indentifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan are a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.

It will also be necessary in DY 2 to develop and test data systems to find measurement tool for improvement work on patient experience targets that are real-time .. The process milestone to

is necessary due to timing delays of other survey results and need for direct feedback to specific interventions for patient experience that will be implemented.

In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This would include intervention impacts, learning from follow up on successes or failures and identified best practices. This feedback is significant to adjusting plans findings and continued engagement of stakeholders.

The target for the outcome measure is to increase patient satisfaction scores by 20% by the end of the waiver period. An increase in patient satisfaction scores will be utilized as a measurement of the effectiveness of improvement work on targeted patient experiences.

Outcome Measure Valuation:

Denton Regional Medical Center defined the population that will be directly impacted by the project as patients with Medicare and all patients who are the target of HCAHPS survey. The percentage of the population expected to be positively impacted by the project is all patients surveyed, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed to determine the value to the health care system for each positive outcome realized as the result of our project. It was estimated based on CMS published penalties that in 5 years for not achieving satisfactory patient experience levels, 1.5% of Medicare revenues were in jeopardy. The Medicare average volume per year of 4,500 cases and rate per Medicare case of $8,827 was used to calculate the estimated loss of revenues using these penalty % for DY 2- 0.50%, DY 3- 0.75%, DY 4-0.94%, and DY5 -1.5% . This totaled $1,748,045 for a 5 year period.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, patient experience improves, which results from improved safety and quality of care that better health outcomes and reduced costs. This was estimated a portion of potential revenue value and totaled $349,609. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, his or quality of life is improved, productivity is increased, and there is a reduced burden on society. This was estimated a portion of potential revenue value and totaled $ 348,443.

The total value of the project was calculated at $2,446,907. Approximately 79% of the project value was assigned to the Category 2 project, $1,934,127 and 21% to the Category 3 project, $511,970.

111905902.3.3	*3.IT-6.1*	*Percent Improvement over baseline of patient satisfaction scores*	
Denton Regional Medical Center			*111905902*
Related Category 1 or 2 Projects::	*111905902.2.2*		
Starting Point/Baseline:	*HCAHPS Grand Composite scores Q4 2010-Q3 2011 of 69%*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans] Metric 1: submission of plan Goal: Plan Data Source: Patient Satisfaction Improvement Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $28,307 **Process Milestone 2** [P- 2]: Develop and test data systems Metric 1: Complete testing systems and development of survey Goal: Establish measurement tool from data systems Data Source: Survey tool Process Milestone 2 Estimated Incentive Payment: $28,306	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: submission of documentation of findings and communication Goal: stakeholder meetings Data Source: Patient Satisfaction Improvement Plan Process Milestone 3 Estimated Incentive Payment: $98,422	**Outcome Improvement Target 1** [IT 6.1]: Improvement Target: 10% improvement over baseline Data Source: HCAHPS hospitals survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $105,291	**Outcome Improvement Target 2** [IT 6.1]: Improvement Target: 20% improvement over baseline Data Source: HCAHPS hospitals survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $251,644

111905902.3.3	*3.IT-6.1*	*Percent Improvement over baseline of patient satisfaction scores*	
Denton Regional Medical Center			*111905902*
Related Category 1 or 2 Projects::	*111905902.2.2*		
Starting Point/Baseline:	*HCAHPS Grand Composite scores Q4 2010-Q3 2011 of 69%*		
Year 2 (10/1/2012 – 9/30/2013)	**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: $56,613	Year 3 Estimated Outcome Amount: $98,422	Year 4 Estimated Outcome Amount: $105,291	Year 5 Estimated Outcome Amount: $251,644
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $511,970			

Title of Outcome Measure (Improvement Target): IT-12.2 Cervical Cancer Screening (HEDIS 2012)

Unique RHP outcome identifier: 094194002.3.1

Performing Provider Name/TPI: Doctors Hospital at White Rock Lake/094194002

Outcome Description

IT-12.2 Cervical Cancer Screening (HEDIS 2012) (Non-standalone Measure)

Through improved access to primary care and expanded women's services and education, this project will increase the number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years, first establishing a baseline.

Rationale:

As a result of increasing access to a medical home, patients that are high-risk or with chronic disease are more likely to receive appropriate follow-up care and preventative care. Through increased access to these primary care services, patients that would have been otherwise unable to seek basic primary care will receive increased screenings and potentially avoid serious medical complications that result from infrequent care. Early interventions resulting from screenings are a life-changing benefit for the patient, and will ultimately result in a cost-savings to the healthcare delivery system.

Process Milestones:

DY2:

- Milestone P1: Project Planning – engage stakeholders through combining education and nurse/clinical resources, identify current capacity and needed resources, determine timelines and document implementations plans.

DY3:

- Milestone P2: Establish baseline rates - determine how many women, aged 21 through 64, who have named the clinic as their home physician's office receive a cervical cancer screening.

Outcome Improvement Targets for Each Year:

DY4:

- Milestone P3: Increase the number of women by [TBD] over DY3 baseline rate.

DY5:

- Milestone P5: Increase the number of women by [TBD] over DY3 baseline rate.

Outcome Valuation:

The project's value is found most directly through its enhancement of Mission East Dallas' women's health programs, including cervical cancer screening. The project supports physicians, nurses, Medicaid enrollment specialists, prescription management and support, Information Technology support, and other administrative support. This project enhances services that are scheduled to be lost through Project Access Dallas, including coordination, referrals, supplemental clinical/physician support, and transportation. This project relates to the value of Project 094194002.2.1, which was developed using the RHP 9 scoring criteria guidance and criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

Further valuation was determined using the Community Needs Assessment for the region and through researching numerous preventive care materials.

References

Ann S. O'Malley, "After-Hours Access To Primary Care Practices Linked With Lower Emergency Department Use And Less Unmet Medical Need," Health Affairs, no. (2012): doi: 10.1377/hlthaff.2012.0494

094194002.3.1	*IT 12.2*	*Cervical Cancer Screening (HEDIS 2012)*	
Doctors Hospital at White Rock Lake			*094194002*
Related Category 1 or 2 Projects	*094194002.2.1*		
Starting Point/Baseline	*TBD in DY2*		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone P1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. Data Source: Project Planning Documentation Estimated Incentive Payment: $32,604	**Process Milestone P2:** Establish baseline rates Data Source: EHR data Estimated Incentive Payment*:* $40,633	**Outcome Improvement Target 1** [IT-12.2]: Cervical Cancer Screening (HEDIS 2012) Improvement Target: [TBD] improvement over DY3. Data Source: EHR; claims. Improvement Target Incentive Payment*:* $69,077	**Outcome Improvement Target 1** [IT-12.2]: Cervical Cancer Screening (HEDIS 2012) Improvement Target: [TBD] improvement over DY3. Data Source: EHR; claims. Estimated Incentive Payment*:* $237,463
Year 2 Estimated Outcome Amount: Estimated $32,604	Year 2 Estimated Outcome Amount: $40,633	Year 2 Estimated Outcome Amount: $69,077	Year 2 Estimated Outcome Amount: $237,463
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $379,777			

97899

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059

Unique RHP outcome identifier: 094194002.3.2

Performing Provider Name/TPI: Doctors Hospital at White Rock Lake/094194002

Outcome Description

IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 (Stand-alone Measure)

Through engagement, education, and identification, this project will increase diabetes education, establish a baseline, provide testing to an increased number of indigent care patients, and ultimately produce an outcome of improvements in the percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c (HbA1c) control >9.0%.

Data Source: EHR, Registry, Claims, Administrative Clinical Data

Rationale:

As a result of increasing access to a medical home, patients that are high-risk or with chronic disease, such as diabetes, are more likely to receive appropriate follow-up care and proper disease management. 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. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Diabetes control can improve the quality of life for millions of Americans and lower costs to the healthcare system. Patients that are assigned to a medical home will have access to the healthcare and resources they need to effectively manage their disease.

Process Milestones:

DY2:

- Milestone P1: Project Planning – engage stakeholders through combining education and nurse/clinical resources, identify current capacity and needed resources, determine timelines and document implementation plans.

DY3:

- Milestone P2: Establish baseline rates. Clinic personnel will keep a record of the number of patients within this diabetic category to establish a baseline rate for improvement in DY4 and DY5.

Outcome Improvement Targets for Each Year:

DY4:

- Decrease the number of patients with diabetes who had hemoglobin A1c (HbA1c) control >9.0% by [TBD] over DY3 baseline.

DY5:

- Decrease the number of patients with diabetes who had hemoglobin A1c (HbA1c) control >9.0% by [TBD] over DY3 baseline.

Outcome Valuation:

Doctors Hospital at White Rock Lake will work with Mission East Dallas to increase diabetes education, treatment, and care. The project supports physicians, nurses, Medicaid enrollment specialists, prescription management and support, Information Technology support, and other administrative support in accomplishing metrics and milestones. This project enhances services that are scheduled to be lost through Project Access Dallas, including coordination, referrals, supplemental clinical/physician support, and transportation.

This project relates to the value of 094194002.2.1, which was developed using the RHP 9 scoring criteria guidance and criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

Further valuation was determined using the Community Needs Assessment for the region and through researching numerous preventive care materials.

094194002.3.2	*IT 1.10*	*DIABETES CARE: HBA1C POOR CONTROL (>9%)*	
Doctors Hospital at White Rock Lake			*094194002*
Related Category 1 or 2 Projects	*094194002.2.1*		
Starting Point/Baseline	*TBD in DY2*		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone P1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. Data Source: Project Planning Documentation Incentive Payment: $32,604	**Process Milestone P2:** Establish baseline rates Data Source: EHR data Estimated Incentive Payment: $40,633	**Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 Improvement Target: [TBD] improvement over DY3. Data Source: EHR; claims. Incentive Payment: $69,077	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 Improvement Target: [TBD] improvement over DY3. Data Source: EHR; claims. Incentive Payment: $237,462
Year 2 Estimated Outcome Amount: $32,604	Year 3 Estimated Outcome Amount: $40,633	Year 4 Estimated Outcome Amount: $69,077	Year 5 Estimated Outcome Amount: $237,462
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $379,776			

Title of Project: IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059

Unique RHP outcome identifier: 094194002.3.3

Performing Provider Name/TPI: Doctors Hospital at White Rock Lake/094194002

Outcome Description

IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059

Through engagement, education, and identification, this project will increase diabetes education, establish a baseline, provide testing to an increased number of indigent care patients, and ultimately produce an outcome of improvements in the percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c (HbA1c) control >9.0%.

Rationale:

As a result of increasing access to a medical home, patients that are high-risk or with chronic disease, such as diabetes, are more likely to receive appropriate follow-up care and proper disease management. 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. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Diabetes control can improve the quality of life for millions of Americans and lower costs to the healthcare system. Patients that are assigned to a medical home will have access to the healthcare and resources they need to effectively manage their disease.

Process Milestones:

DY2:

- Milestone P1: Project Planning – engage stakeholders through combining education and nurse/clinical resources, identify current capacity and needed resources, determine timelines and document implementation plans.

DY3:

- Milestone P2: Establish baseline rates. Clinic personnel will keep a record of the number of patients within this diabetic category to establish a baseline rate for improvement in DY4 and DY5.

Outcome Improvement Targets for Each Year:

DY4:

- Decrease the number of patients with diabetes who had hemoglobin A1c (HbA1c) control >9.0% by [TBD] over DY3 baseline.

DY5:

- Decrease the number of patients with diabetes who had hemoglobin A1c (HbA1c) control >9.0% by [TBD] over DY3 baseline.

Rationale for Process Milestones and Improvement Targets: Process Milestones to conduct Project Planning in DY2 and Establish Baseline rates in DY3 were chosen to appropriately plan for and implement a strategy for reducing HbA1c poor control. In DY4 and DY5, Doctors Hospital at White Rock Lake plans to reduce rates over the DY3 baseline by [TBD] in DY4 and by [TBD] in DY5.

Outcome Valuation

In concert with its Category 2.12 Care Transitions Programs project, Doctors Hospital at White Rock Lake will utilize this project to increase diabetes education, treatment, and care with low-income patients it serves. This project relates to the value of Project 094194002.2.2 which was developed using the RHP 9 scoring criteria guidance and criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

Further valuation was determined using the Community Needs Assessment for the region, researching cost of PPRs, PPCs, ED utilization, and other costs presented by untreated, undertreated, and under-informed diabetic populations, and through researching numerous preventive care materials.

094194002.3.3	*IT 1.10*	*DIABETES CARE: HBA1C POOR CONTROL (>9%)*	
Doctors Hospital at White Rock Lake			*094194002*
Related Category 1 or 2 Projects	*094194002.2.~~1~~2*		
Starting Point/Baseline	*TBD in DY2*		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone P1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. Data Source: Project planning documentation. Incentive Payment*:* $16,302	**Process Milestone P2:** Establish baseline rates Data Source: EHR, claims Estimated Incentive Payment*:* $20,317	**Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 Improvement Target: [TBD] improvement over DY3. Data Source: EHR; claims. Incentive Payment: $34,538	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 Improvement Target: [TBD] improvement over DY3. Data Source: EHR; claims. Incentive Payment: $102,858
Year 2 Estimated Outcome Amount: $16,302	Year 3 Estimated Outcome Amount: $20,317	Year 4 Estimated Outcome Amount: $34,538	Year 5 Estimated Outcome Amount: $102,858
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $174,015			

97899

Title of Outcome Measure (Improvement Target): 3.IT-6.1 Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores measuring patient's overall health status/functional status. (3.IT-6.1)

Unique RHP outcome identification number(s): 121988304.3.1

Performing Provider Name/TPI: Lakes Regional MHMR Center / 121988304

Outcome Measure Description:
The project will implement outcome measure IT-6.1 to measure improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status.

Process Milestones:

- In DY3, we will establish the baseline rate for patient satisfaction with overall health status/functional status in 30 individuals.

Outcome Improvement Targets for each year:

- In DY4, Improvement Target-6.1 is to achieve 20% improvement over baseline of patient satisfaction scores measuring patient's overall health status/functional status in at least 100 individuals. Percentage will be measured by percent improvement in targeted patient satisfaction domain (numerator) over number of patients who were administered the survey (denominator).

- In DY5, Improvement Target-6.1 is to achieve 40% improvement over satisfaction scores in DY4 measuring patient's overall health status/functional status in at least 150 individuals by end of Waiver. Percentage will be measured by percent improvement in targeted patient satisfaction domain (numerator) over number of patients who were administered the survey (denominator).

By the end of the Waiver, our goal is to achieve 60% improvement over baseline of patient satisfaction scores regarding satisfaction with patient's overall health status/functional status.

Rationale:
Research has shown that there is a much greater instance of health problems in the IDD population[526]. The program staff will monitor mental and physical health status and outcomes to facilitate integrated care, improvement of patient satisfaction and outcomes for the target

[526] Jansen, D., Krol, B., Groothoff, J. and Post, D. (2004). People with intellectual disabilities and their health problems: a review of comparative studies. *Journal of Intellectual Disability Research* 48 (2): 93-102.

population[527]. Research has shown that the use of Intensive Case Management reduced the number, confidence interval and duration of inpatient admissions, reducing the number of reported needs and increasing patient satisfaction, as well as the cost of care borne by the health sector[528]. The CGCAHPS survey produces ". . . comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers"[529]. Sharing survey results with other agencies and providers in the Region regarding consumer satisfaction with overall health and functional status will bring about improvements in the overall health system for individuals with IDD/ASD/MH, since "[p]ublic reporting of the survey results is designed to create incentives for institutions to improve their quality of care." [530] Sharing survey results with stakeholders will result in a greater awareness of the efficacy of the crisis respite wraparound model in improving life satisfaction, following better self-management skills and improved follow-up to care.

Lakes Regional has the data to evaluate patient satisfaction with overall health status/functional status at this time. We will establish a baseline rate to measure satisfaction by implementing the CG-CAHPS and administering it to at least 30 individuals. The CG-CAHPS is a standardized survey instrument and data collection methodology for measuring patients' perspectives on health care. Working collaboratively with the target population to highlight the importance of implementing evidence-based approaches to care tailored to individual needs will involve the target population in being accountable for participation in consistent self-monitoring. Better control over physical and psychiatric symptoms has shown to lead to greater consumer and family member satisfaction, as noted above.

Additionally, Lakes Regional will collaborate with 39 other MHMR centers across the state 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 data through shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for the project.

Outcome Measure Valuation:

The valuation for this project was based on an established economic evaluation model and extensive literature review conducted by professionals in the field and at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research.

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[527] Jansen, D., Krol, B., Groothoof, J. and Post D. (2006). Towards improving medical care for people with intellectual disability living in the community: possibilities of integrated care. *Journal of Applied Research in Intellectual Disabilities.* 19: 214-218.

[528] Hassiotis. A. (2002). Community mental health services for individuals with intellectual disabilities: issues and approaches to optimizing outcomes. *Disability Management and Health Outcomes* 10 (7): 409-417.

[529] RHP Planning Protocol, Category 3 Quality Improvements, 398.

[530] ibid

Outcome measures will be valued by assessing community needs identified for Region 9 addressed through the RHP plan, such as the need for more care coordination and overuse of emergency department services. When patients experience a fragmented service system between behavioral health and primary care, as well as a lack of access to coordinated care, they experience lack of satisfaction and inability to self-monitor and manage symptoms effectively as a result. Supporting individuals in the community at a lesser cost than hospital or institutional care, and avoiding costs in emergency departments and psychiatric hospitals is a predictor to overall improvement in coordinated care in the community, and greater quality of life satisfaction. [531]

DY2 – There is no process milestone in DY2; the focus of Quality Improvement will be on activities in DY2 in the related project (1.13.1) involving gathering input from stakeholder meetings, conducting mapping and gap analyses regarding Community Need in the project area, and defining project requirements. (Outcome valuation payment/process milestone are not required in DY2 for this project.)
DY3 – Process Milestone (P-2) to establish the baseline rate for improvement in patient satisfaction with overall health/functional status in 30 individuals. The need to measure improvement in this domain will be accomplished by hiring part-time Quality Assurance staff to survey the target population to achieve a baseline for outcome measure 3IT-6.1. Participants will be surveyed to assess their experience in the current service system as it relates to meeting their needs.
DY4 – Improvement Target 6.1 is to establish 20% improvement over baseline of patient satisfaction scores in at least 100 individuals in the selected domain. Nursing staff will administer surveys to measure improvement over baseline in the selected domain. It is expected that service recipients will experience improved overall satisfaction with services due to improved quality of life; improved satisfaction is expected to lead to a decrease in overuse of emergency department services and other barriers to access to care in the community for the target population, as well as improved ability to successfully and consistently self-manage symptoms in the community.
DY5 – Improvement Target 6.1 to establish 40% improvement over DY4 in at least150 individuals and 60% improvement overall in patient satisfaction scores in selected domain: see approach/methodology for IT-6.1 for DY4.

3IT-6.1 Percent improvement over baseline of patient satisfaction scores. A process milestone in Year 3 will establish the baseline rate for improvement in patient satisfaction with overall health/functional status; Improvement targets in DYs 4 and 5 will establish percent improvement over baseline in patient satisfaction scores in at least 250 individuals, ending Year 5 with a 60% improvement over baseline in patient satisfaction scores.

[531] Jansen, D., Krol, B., Groothoof, J. and Post D. (2006). Towards improving medical care for people with intellectual disability living in the community: possibilities of integrated care. *Journal of Applied Research in Intellectual Disabilities.* 19: 214-218.

Size – The project will involve hiring one nursing staff and one part-time Quality Assurance staff to administer surveys, provide monitoring and follow-up and documentation of responses, and collection and maintenance of data on potentially and approximately 250 respondents receiving care at the Crisis Respite/Wraparound program.

Project Scope – The proposed project is projected to measure satisfaction with improvement in overall health status/functional status in approximately 250 individuals (children and adults) who are dually diagnosed in Ellis and Navarro counties.

Population Served – The population targeted to be served are individuals dually diagnosed with IDD/ASD/MH (one or all of those diagnoses).

Community Benefit and Cost Avoidance – As noted above, improved satisfaction with overall health outcomes will lead to improved self-maintenance of physical and psychiatric health outcomes, as well as less frequent need for hospital visits and stays that result from crisis/exacerbation of symptoms. Consistently implementing monitoring and follow-up in the approach to care will lead to cost avoidance in that patients will no longer require the support of more expensive settings for symptom maintenance. Research has shown that the use of Intensive Case Management reduced the number, confidence interval and duration of inpatient admissions, reducing the number of reported needs and increasing patient satisfaction, as well as the cost of care borne by the health sector. [532] Sharing evidence-based data with other providers on patient satisfaction in this area will serve to "enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment" [533]

Addressing Priority Community Need – Currently there is no crisis respite/wraparound program in the targeted area to serve the needs of the target population when in crisis, resulting in the frequent use of more restrictive and expensive settings for care, such as psychiatric hospitals and institutional settings.

Estimated Local Funding – (see table)

[532] Hassiotis. A. (2002). Community mental health services for individuals with intellectual disabilities: issues and approaches to optimizing outcomes. *Disability Management and Health Outcomes* 10 (7): 409-417.
[533] RHP Protocol, Category 3 Quality Improvements, 398.

121988304.3.1	*3IT-6.1*	*Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status*		
Lakes Regional MHMR Center			*121988304*	
Related Category 1 or 2 Projects:	*121988304.1.1: Development of behavioral health crisis stabilization services as alternatives to hospitalization; Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system*			
Starting Point/Baseline:	*Established in Year 3*			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**	
N/A – during DY-2	**Process Milestone 1 [P-2]:** Establish baseline rate for improvement in patient satisfaction with overall health status/functional status in 30 individuals. Metric**:** Numerator: Percent improvement in targeted patient domain at baseline. Denominator: Number of patients who were administered the survey. Data Source: Patient Survey Process Milestone 1 Estimated Incentive Payment: $161,675	**Outcome Improvement Target 1 [IT-6.1]:** Improvement Target: 20% improvement over baseline of patient satisfaction scores in at least 100 individuals. Metric**:** Numerator: Percent improvement in patient satisfaction with overall health status/functional status. Denominator: Number of patients who were administered the survey. Data Source: Patient Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $195,732	**Outcome Improvement Target 2 [IT-6.1]:** Improvement Target: 40% improvement of patient satisfaction scores from DY4 in at least 150 individuals. Metric: Numerator: Percent improvement in patient satisfaction with overall health status/functional status. Denominator: Number of patients who were administered the survey. Data Source: Patient Survey Outcome Improvement Target 3 Estimated Incentive Payment*:* $475,177	
Year 2 Estimated Outcome Amount: N/A	**Year 3 Estimated Outcome Amount**: $**161,675**	**Year 4 Estimated Outcome Amount: $195,732**	**Year 5 Estimated Outcome Amount**: **$475,177**	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** **$832,584**				

Title of Outcome Measure (Improvement Target): 3.IT-6.1 Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores, measuring patient's overall health status/functional status. (3.IT-6.1)

Unique RHP Outcome Identification Number: 121988304.3.2

Performing Provider Name/TPI: Lakes Regional MHMR Center/121988304

Outcome Description

IT-6.1: Percent improvement over baseline of patient satisfaction scores, measuring patient's overall health status/functional status

Process Milestones:
*****In DY3, we will develop and test data systems related to measuring patient satisfaction and survey an initial group of 30 individuals to establish the patient satisfaction baseline improvement goal.
Outcome Improvement Targets for each year:

- In DY4, Improvement Target-6.1 is to achieve 20% improvement over baseline of patient satisfaction scores measuring patient's overall health status/functional status in at least 75 individuals. Percentage will be measured by percent improvement in targeted patient satisfaction domain (numerator) over number of patients who were administered the survey (denominator).

- In DY5, Improvement Target-6.1 is to achieve 40% improvement over satisfaction scores in DY4 measuring patient's overall health status/functional status in at least 135 individuals by end of Waiver. Percentage will be measured by percent improvement in targeted patient satisfaction domain (numerator) over number of patients who were administered the survey (denominator).

By the end of the waiver, our goal is to achieve 60% improvement over baseline of patient satisfaction scores regarding satisfaction with patient's overall health status/functional status.

Rationale

Our telemedicine/ telehealth program will develop and incorporate data systems to provide information and feedback with technical and clinical processes. This data will be used to help us manage the expansion of the program in Kaufman County and ensure that we are continuously improving the quality of the services we provide to ensure patient satisfaction. Although this Telemedicine/Telehealth Introduction/Expansion Project will enable services from multiple provider specialties, it will share significant focus with the Lakes Regional Crisis Respite – Behavioral Support Wraparound Program Project. Within the IDD (Intellectual and

Developmental Disabilities) population, research has shown that there is a much greater instance of health problems[534]. With the help of telemedicine/telehealth technology, program staff will monitor mental and physical health status and outcomes to facilitate integrated care, improvement of patient satisfaction and outcomes for the target population[535]. The specific ACT model planned for the program will result in better control of psychiatric symptoms, better quality of life overall, and greater consumer and family member satisfaction[536]. The projected outcomes relate to an improvement in access to care, the quality of care and health outcomes, as well as an overall improvement in health for the target population. The CG-CAHPS survey produced comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers[537].

Lakes Regional has the data to evaluate patient satisfaction with overall health status/functional status at this time. Additionally, Lakes Regional will collaborate with 39 other MHMR centers across the state to develop and 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 data through shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for the project

The sharing of data (overall health survey results) between agencies and providers in the region regarding consumer satisfaction will result in a greater awareness of the efficacy of the crisis respite wraparound model in improving life satisfaction following better self-management skills and follow-up to care. Identified within the Crisis Respite Project there is significant data analysis planned with encounter based assessments to show and measure improvement in customer satisfaction in health/ functional status.

Outcome Measure Valuation:

Approach/Methodology:
DY3 – Process Milestone (P-3) will involve developing and testing data systems related to measuring patient satisfaction to establish a methodology for measuring patient satisfaction in Years 4 and 5.

- DY4 – Improvement Target 6.1 will establish a 20% improvement over baseline of patient satisfaction scores measuring patient's overall health status/functional status in at least 75 additional individuals. Percentage will be measured by percent improvement in targeted patient satisfaction domain (numerator) over number of patients who were administered the survey (denominator).

[534] Journal of Intellectual Disability Research 48 (2): 93-102
[535] Journal of Applied Research in Intellectual Disabilities. 19: 214-218
[536] Phillips et al, 2001. . .Teague et al, 1995
[537] RHP Planning Protocol, page 398

- DY5 – Improvement Target 6.1 will establish a 40% improvement over satisfaction scores in DY4 measuring patient's overall health status/functional status in at least 135 additional individuals by end of Waiver. Percentage will be measured by percent improvement in targeted patient satisfaction domain (numerator) over number of patients who were administered the survey (denominator).

Rationale/Justification: Our telemedicine/telehealth project will provide flexibility for the type of services and where the connections between providers can be established. With the rural nature of Kaufman County, the internet cloud based implementation planned for the project will open up the area for video communication between doctors' offices, schools, hospitals, jails, behavioral health clinics, and just about anywhere that there is broadband internet access (providers working out of their homes). The possibilities for expansion of this program are numerous and the services provided will result in overall cost reductions for the region. This project was valued based on studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: "Valuing Access to Timely Services through Telemedicine." These studies were completed through a contract with Center for Health Care Services. These valuation studies used cost-utility analysis which measure program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency room visits that are avoided).

Outcome Measure: 3IT-6.1 Percent improvement over baseline of patient satisfaction scores. A process milestone in Year 3 will establish baseline for improvement in patient satisfaction with overall health/functional status; Improvement targets in DY's 4 and 5 will establish percent improvement over baseline in patient satisfaction scores, ending Year 5 with a 60% improvement over baseline in patient satisfaction scores.

Size – In providing the new technology to clinical programs in the region, the telemedicine program will require all of the needed infrastructure and support operations. This includes the implementation of data line enhancements, internet-cloud private network connectivity (VPN), and server based audio/video processing and session management. The program will involve collection and maintenance of data on potentially 210 clients over the course of the waiver period.

Project Scope – The proposed project is projected to measure satisfaction with improvement in overall health status/functional status for those receiving telemedicine/telehealth during the waiver period. It is estimated the potential client base could reach 210 individuals over the waiver period in Kaufman County**.**

Population Served – The population targeted to be served is individuals with a primary behavioral health and/or dually diagnosed with IDD/ASD (Autism Spectrum Disorders)/MH (one or all of those diagnoses).

Community Benefit and Cost Avoidance – Improved satisfaction with overall health outcomes will lead to improved self-maintenance of physical and psychiatric health outcomes, as well as less frequent need for hospital visits and stays that result from crisis/exacerbation of symptoms. Consistently implementing monitoring and follow-up in the approach to care will lead to cost avoidance in that patients will no longer require the support of more expensive settings for symptom maintenance. Sharing evidence-based data with other providers on patient satisfaction in this area will serve to "enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment"[538].

Addressing Priority Community Need – Currently there is no telemedicine/ telehealth program to support routine access to specialty care or for crisis respite/wraparound services in Kaufman County. This results in the frequent use of more restrictive and expensive settings for care, such as psychiatric hospitals, emergency rooms and institutional settings.

Related Category 1 and/or 2 projects

121988304.1.2: Implement Telemedicine Program to Provide or expand specialist referral services in an area identified a needed to the region.

[538] RHP Protocol, page 398

121988304.3.2	*3.IT- 6.1*	*Percent improvement over baseline of patient satisfaction scores re: patient's overall health status/functional status*		
Lakes Regional MHMR Center				*121988304*
Related Category 1 or 2 Projects:	*121988304.1.2 (1.7.1): Lakes Regional Telemedicine/Telehealth*			
Starting Point/ Baseline:	*Baseline for improvement of the target population in patient satisfaction with overall health status/functional status will be established in Year 3.*			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**	
N/A	**Process Milestone 1 [P-3)]** Develop and test data systems related to measuring patient satisfaction. **Metric:** Completed data system methodology for measuring patient satisfaction. Data Source: Project documentation and data systems **Process Milestone 1 Estimated Incentive Payment**: $63,213	**Outcome Improvement Target 1** [IT-6.1]: **Improvement Target**: 20% improvement over DY-3 baseline (based on 30 individuals) patient satisfaction scores in at least 75 additional individuals. **Metric:** Numerator: Percent improvement in patient satisfaction with overall health status/functional status. Denominator: Number of patients who were administered the survey (75 minimum). **Data Source**: Patient Survey **Outcome Improvement Target 2 Estimated Incentive Payment***: $45,914*	**Outcome Improvement Target 2** [IT-6.1]: **Improvement Target**: 40% improvement over DY-3 baseline of patient satisfaction scores in at least 135 additional individuals. **Metric:** Numerator: Percent improvement in patient satisfaction with overall health status/functional status. Denominator: Number of patients who were administered the survey (135 minimum) **Data Source**: Patient Survey **Outcome Improvement Target 3 Estimated Incentive Payment***: $95,074*	
Year 2 Estimated Outcome Amount: N/A	**Year 3 Estimated Outcome Amount**: **$64,213**	**Year 4 Estimated Outcome Amount: $45,914**	**Year 5 Estimated Outcome Amount**: **$95,074**	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** **$205,201**				

Title of Outcome Measure (Improvement Target): 3.IT-6.1 Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores, measuring patient's overall health status/functional status. (3.IT-6.1)

Unique RHP Outcome Identification Number:

121988304.3.3 (IT-6.1)

Performing Provider Name/TPI:

Lakes Regional MHMR Center/121988304

Outcome Description:

OD- 6 Patient Satisfaction

3.IT-6.1 Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores, measuring patient's overall health status/functional status.

*In DY3, Process Milestone 3 [P-4] Conduct Plan, Do, Study, Act (PCSA) cycles to improve data collection and intervention activities; Outcome Improvement Target IT-6.1 to achieve a mean of 10% improvement over baseline of individual patient satisfaction scores as averaged in the participant pool.

*In DY 4 Outcome Improvement Target IT-6.1 to achieve a mean of 10% improvement over baseline of individual patient satisfaction scores as averaged in the participant pool.

*In DY 5, Outcome Improvement Target IT-6.1 to achieve a mean of 15% improvement over baseline of individual patient satisfaction scores as averaged in the participant pool.

By the end of the waiver, Lakes Regional Mental Health Mental Retardation Center (LRMHMRC) goal is to achieve 15% improvement over individual baseline of individual satisfaction scores as averaged in the participant cumulative data regarding satisfaction with program participants' overall health status/functional status.

Rationale:

Process milestones of Project Planning (with necessary components), Establishing Baselines, and conducting PDSA cycles with some details added were adequate general descriptions ~~of the area of concern~~ in creating the LRMHMRC Cognitive Enhancement Therapy (CET) project. The CET project is to introduce participants to social awareness and cognitive development exercises thereby improving their social cognition and functioning in the community. The State contracted services they are currently provided will change to the functional assessment of their condition and improvement ~~on a quarterly basis~~ through use of the Adult Needs Skills Assessment (ANSA) and Child and Adolescent Needs and Strength (CANS) standardized

assessment instruments. A project improvement tracking measure will be the SP-36 quality of life measurement to inform the individual and the project of the broader impact the service ~~change~~ is having. Finally, the outcome improvement target measure of the level of satisfaction with services ~~using~~ will use the validated instrument Mental Health Statistics Improvement Program Consumer Survey (MHSIP). Use of the MHSIP provides a standard instrument and protocol for data collection and processing consistent through the development of mental health programs with the effort of Center for Mental Health Services (CMHS) for improvement of state mental health programs. The MHSIP is a validated standardized instrument viewed as an equivalent alternative to the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) for outpatient mental health services. DY2 and DY3 efforts at establishing baselines will inform and likely lead to refinement of gross improvement target estimations.

Lakes Regional has the data to evaluate patient satisfaction with overall health status/functional status at this time. Additionally, Lakes Regional will collaborate with 39 other MHMR centers across the state to develop and 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 data through shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for the project

Outcome Measure Valuation:

The project will implement outcome measure 3.IT-6.1 to measure improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status. This outcome measure will be valued by assessing community needs identified for Region 9 addressed through the RHP Plan, such as the need for more care coordination and overuse of emergency department (ED) services. When patients experience stagnation after stabilization on medications but have no effective service for life improvement in the prodromal aspects of their illness, they experience lack of satisfaction and inability to self-monitor and manage symptoms effectively as a result. Supporting individuals in the community at a lesser cost than hospital or institutional care, and avoiding costs in emergency rooms (ER) and psychiatric hospitals is a predictor to overall improvement in social functioning in the community, and greater quality of life satisfaction. In keeping with the waiver Program Funding Mechanics (PFM) Protocol for the DSRIP pool the approach to valuation followed the formula prescribed on page 27 of the document for Non-Hospital Performing Providers for Category 3 allowing DY2 5%, DY3 10%, DY4 10%, and DY5 20%.

DY3– Process Milestone (P-4) conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities will inform the project for continuous quality improvement. Improvement Target 6.1 to establish a mean of 10% improvement over baseline of individual patient satisfaction scores in selected domain.

DY4 – Improvement Target 6.1 to establish a mean of 10% improvement over baseline of individual patient satisfaction scores in selected domain. It is expected that service recipients will experience improved overall satisfaction with services due to improved quality of life; improved satisfaction is expected to lead to a decrease in overuse of emergency department services and other barriers to access to care in the community for the target population, as well as improved ability to successfully and consistently self-manage symptoms in the community.

DY5 – Improvement Target 6.1 to establish a mean of 15% improvement over baseline of individual patient satisfaction scores in selected domain: See approach/methodology for **IT-6.1 for DY4.**

Rationale/Justification:

Outcome Measure: 3.IT-6.1 Percent improvement over baseline of patient satisfaction scores. Individual responses to the MHSIP survey will be used as baseline to the participants against which to compare end of program responses. The average of the difference in the scores of all the participants in the program over time will serve as a continuing aggregate outcome target to maintain above 15% beginning DY5.

Size – The project will be Cognitive Enhancement Therapy serving six (6) ~~two (2)~~ groups over the waiver of mental health clinic clients weekly with a combined population of 16 to 24 individuals for a total of 168 service hours per graduate over the course of 48 weeks or a possible 12,096 client hours.. DY2 activity is surveying and establishing what portion of the clinic population would meet inclusion criteria.

Project Scope – The proposed project ~~is projected to~~ will measure satisfaction with improvement in overall health status/functional status in the targeted population of identified eligible individuals (minimum of 60) in the Terrell Mental Health Clinic.

Population Served – The population targeted to be served are individuals stable on medications with Serious Mental Illness (SMI).

Community Benefit and Cost Avoidance – Improved satisfaction with overall health outcomes will lead to improved self-maintenance of physical and psychiatric health outcomes, as well as less frequent need for hospital visits and stays that result from crisis/exacerbation of symptoms. Consistently implementing monitoring and follow-up in the approach to care will lead to cost avoidance in that patients will no longer require the support of more expensive settings for symptom maintenance. Sharing evidence-based data with other providers on patient satisfaction in this area will serve to "enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment" (RHP Protocol, page 398).

Addressing Priority Community Need– In keeping with the Region 9 results of the Community Needs Assessment (CN.5) Behavioral Health - the need for services for improvement in the population with SMI leading to lowering health care costs and reducing hospital readmissions through higher functioning participants with greater community efficacy is the focus of the project.

Related Category 1 and/or 2 projects:

Lakes Regional 121988304.2.1 (2.13.1) Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population (Cognitive Enhancement Therapy Program).

121988304.3.3	IT-6.1	Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status	
Lakes Regional MHMR Center			121988304
Related Category 1 or 2 Projects:	(2.13.1) Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population (Cognitive Enhancement Therapy Program) - 121988304.2.1		
Starting Point/Baseline:	Baseline for improvement of the target population in patient satisfaction with overall health status/functional status will be established in Year 3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
N/A	**Process Milestone 1** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project operational plan and PDSA reports. **Process Milestone** 1 Estimated Incentive Payment: **$95,753**	**Outcome Improvement Target 1 [IT-**6.1**]:** Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure) Four (4) primary focus areas of the MHSIP are : 1) General satisfaction 2) Access 3) Quality / appropriateness and 4) Outcomes. **Data Source:** MHSIP surveying of participants **Improvement Target**: 10% improvement over baseline of patient satisfaction scores **Metric:** **Numerator:** Percent improvement in targeted patient satisfaction domain. **Denominator:** Number of patients who were administered the survey: aggregate 30 minimum. **Outcome Improvement Target 2** Estimated Incentive Payment*:* **$101,790**	**Outcome Improvement Target 1 [IT-6.1]:** Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure) Four (4) primary focus areas of the MHSIP are: General satisfaction Access Quality / appropriateness and Outcomes. **Data Source:** MHSIP surveying of participants **Improvement Target**: 15% improvement over baseline of patient satisfaction scores **Metric:** **Numerator:** Percent improvement in targeted patient satisfaction domain. **Denominator:** Number of patients who were administered the survey: aggregate 60 minimum. **Outcome Improvement** Target 3 Estimated Incentive Payment*:* **$220,258**
Year 2 Estimated Outcome Amount: N/A	**Year 3 Estimated Outcome Amount**: $ **95,753**	**Year 4 Estimated Outcome Amount: $101,790**	**Year 5 Estimated Outcome Amount**: **$220,258**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $417,801**			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent Improvement over baseline of patient satisfaction scores

Unique RHP outcome identification number(s): 020979301.3.1

Performing Provider Name/TPI: Las Colinas Medical Center/020979301

Outcome Measure Description:
IT-6.1 Percent Improvement over baseline of patient satisfaction scores. At the end of the 5 year waiver, scores will be improved by 20%. Approximately 23% of our patients are either Medicaid eligible or indigent. We estimate more than 5,000 a year or 22,500 over course of the waiver will be impacted. Of those patients ,23 % are estimated to be Medicaid eligible or indigent. . It is estimated patients impacted will be DY 2-5,299, DY 3-5,564, DY 4-5,731, DY5-5,903. We do actively survey 100 patients a month/1200 a year

Process Milestones:

In DY 2 we will establish baseline data to measure for patient satisfaction scores. In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. It will also be necessary establish a base line to correctly measure the improvement. In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders.

Outcome improvement targets:

The target for the outcome measure is 10% improvement in scores over baseline in DY 4 and 20% over baseline in DY 5.

Rationale

The outcome improvement targets were selected as they are congruent with other goals of the organization and will result in improved health outcome of patients and reduce cost to the health system.

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders (IP /OP, out of hospital providers, etc) are identified and included in the plan. Indentifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan are a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.

It will also be necessary in DY 2 to develop and test data systems to find measurement tool for improvement work on patient experience targets that are real-time .. The process milestone to is necessary due to timing delays of other survey results and need for direct feedback to specific interventions for patient experience that will be implemented.
In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This would include intervention impacts, learning from follow up on successes or failures and identified best practices. This feedback is significant to adjusting plans findings and continued engagement of stakeholders.

The target for the outcome measure is to increase patient satisfaction scores by 20% by the end of the waiver period. An increase in patient satisfaction scores will be utilized as a measurement of the effectiveness of improvement work on targeted patient experiences.

Outcome Measure Valuation

Las Colinas Medical Center defined the population that will be directly impacted by the project as patients with Medicare and all patients who are the target of HCAHPS survey. The percentage of the population expected to be positively impacted by the project is all patients surveyed, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed to determine the value to the health care system for each positive outcome realized as the result of our project. It was estimated based on CMS published penalties that in 5 years for not achieving satisfactory patient experience levels, 1.5% of Medicare revenues were in jeopardy. The Medicare average volume per year of 800 cases and rate per Medicare case of $8,654 was used to calculate the estimated loss of revenues using these penalty % for DY 2- 0.50%, DY 3- 0.75%, DY 4-0.94%, and DY5 -1.5% . This totaled $356,500 for a 5 year period.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, patient experience improves, which results from improved safety and quality of care that better health outcomes and reduced costs. This was estimated a portion of potential revenue value and totaled $260,245 . To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, his or quality of life is improved, productivity is increased, and there is a reduced burden on society. This was estimated a portion of potential revenue value and totaled $ 214,303.

The total value of the project was calculated at $831,048. Approximately 79% of the project value was assigned to the Category 2 project, $657,118 and 21% to the Category 3 project, $173,930

020979301.3.1	*3.IT-6.1*	*Percent Improvement over baseline of patient satisfaction scores*	
Las Colinas Medical Center			*020979301*
Related Category 1 or 2 Projects::	*020979301.2.1*		
Starting Point/Baseline:	*HCAHPS Grand Composite scores Q4 2010-Q3 2011 of 71%*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: submission of plan Goal: Plan Data Source: Patient Satisfaction Improvement Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $9,629 **Process Milestone 2** [P- 2]: Develop and test data systems Metric 1: Complete testing systems and development of survey Goal: Establish measurement tool from data systems Data Source: Survey tool Process Milestone 2 Estimated Incentive Payment: $9,628	**Process Milestone 3** [P-5]: Disseminate findings (i.e. resources utilized, feedback from patients and staff, satisfaction scores), including lessons learned and best practices, to stakeholders Metric 1: submission of documentation of findings and communication Goal: stakeholder meetings Data Source: Patient Satisfaction Improvement Plan Process Milestone 3 Estimated Incentive Payment: $33,404	**Outcome Improvement Target 1** [IT 6.1]: Improvement Target: 10% improvement over baseline Data Source: HCAHPS hospitals survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $35,732	**Outcome Improvement Target 2** [IT 6.1] : Improvement Target: 20% improvement over baseline Data Source: HCAHPS hospitals survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $85,537
Year 2 Estimated Outcome Amount: $19,257	Year 3 Estimated Outcome Amount: $33,404	Year 4 Estimated Outcome Amount: $35,732	Year 5 Estimated Outcome Amount: $85,537
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $173,930			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent Improvement over baseline of patient satisfaction scores

Unique RHP outcome identification number(s): 094192402.3.1

Performing Provider Name/TPI: Medical Center of Lewisville/094192402

Outcome Measure Description

IT-6.1 Percent Improvement over baseline of patient satisfaction scores. At the end of the 5 year waiver, scores will be improved by 20%.The target population is IP, ED and OP patients at the hospital. Approximately 36% of our patients are either Medicaid eligible or indigent. . We estimate 7,600 patients a year or 40,600 over the course of the waiver will be impacted. We do actively survey 100 patients a month/1200 a year

Process Milestones:

In DY 2 we will establish baseline data to measure for patient satisfaction scores. In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan.In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders.

Outcome improvement targets:

The target for the outcome measure is 10% improvement in scores over baseline in DY 4 and 20% in DY 5.

Rationale

The outcome improvement targets were selected as they are congruent with other goals of the organization and will result in improved health outcome of patients and reduce cost to the health system.

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders (IP /OP, out of hospital providers, etc) are identified and included in the plan. Indentifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan are a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.

It will also be necessary in DY 2 to develop and test data systems to find measurement tool for improvement work on patient experience targets that are real-time .. The process milestone to

is necessary due to timing delays of other survey results and need for direct feedback to specific interventions for patient experience that will be implemented.
In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This would include intervention impacts, learning from follow up on successes or failures and identified best practices. This feedback is significant to adjusting plans findings and continued engagement of stakeholders.

The target for the outcome measure is to increase patient satisfaction scores by 20% by the end of the waiver period.. An increase in patient satisfaction scores will be utilized as a measurement of the effectiveness of improvement work on targeted patient experiences.

Outcome Measure Valuation

In valuing our project, we took into account patient safety and quality improvements, cost avoidance, mortality, financial impact on patients and community and resources needed to impact the measure.

Medical Center of Lewisville defined the population that will be directly impacted by the project as patients with Medicare and all patients who are the target of HCAHPS survey. The percentage of the population expected to be positively impacted by the project is all patients surveyed, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed to determine the value to the health care system for each positive outcome realized as the result of our project. It was estimated based on CMS published penalties that in 5 years for not achieving satisfactory patient experience levels, 1.5% of Medicare revenues were in jeopardy. The Medicare average volume per year of 2,150 cases and rate per Medicare case of $8,634 was used to calculate the estimated loss of revenues using these penalty % for DY 2- 0.50%, DY 3- 0.75%, DY 4-0.94%, and DY5 -1.5% . This totaled $771,480 for a 5 year period.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, patient experience improves, which results from improved safety and quality of care that better health outcomes and reduced costs. This was estimated a portion of potential revenue value and totaled $154,296. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, his or quality of life is improved, productivity is increased, and there is a reduced burden on society. This was estimated a portion of potential revenue value and totaled $ 149,195.

The total value of the project was calculated at $1,074,974. Approximately 79% of the project value was assigned to the Category 2 project, $849,981 and 21% to the Category 3 project, $224,900.

094192402.3.1	*3.IT-6.1*	*Percent Improvement over baseline of patient satisfaction scores*	
	Medical Center of Lewisville		*094192402*
Related Category 1 or 2 Projects::	*094192402.2.1*		
Starting Point/Baseline:	*HCAHPS Grand Composite scores Q4 2010-Q3 2011 of 70%*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans] Metric 1: submission of plan Goal: Plan Data Source: Patient Satisfaction Improvement Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,435 **Process Milestone 2** [P- 2]: Develop and test data systems Metric 1: Complete testing systems and development of survey Goal: Establish measurement tool from data systems Data Source: Survey tool Process Milestone 2 Estimated Incentive Payment: $12,435	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: submission of documentation of findings and communication Goal: stakeholder meetings Data Source: Patient Satisfaction Improvement Plan Process Milestone 3 Estimated Incentive Payment: $43,243	**Outcome Improvement Target 1** [IT 6.1]: Improvement Target: 10% improvement over baseline Data Source: HCAHPS hospitals survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $46,258	**Outcome Improvement Target 2** [IT 6.1] : Improvement Target: 20% improvement over baseline Data Source: HCAHPS hospitals survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $110,619
Year 2 Estimated Outcome Amount:: $24,870	Year 3 Estimated Outcome Amount: $43,243	Year 4 Estimated Outcome Amount: $46,258	Year 5 Estimated Outcome Amount: $110,619
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $224,990			

Title of Outcome Measure (Improvement Target): IT-4.8 Sepsis mortality

Unique RHP outcome identification number(s): 094192402.3.2

Performing Provider Name/TPI: Medical Center of Lewisville/094192402

Outcome Measure Description:

IT-4.8 Sepsis mortality is the percentage of those patients diagnosed with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction that expire during hospitalization. Mortality rates are very high in US from sepsis. With earlier diagnosis of sepsis and compliance with Sepsis Resuscitation and Management Bundles we will decrease the mortality rate. We expect to diagnose and treat 647 sepsis patients (estimated at DY 1- 93, DY2-112, DY 3- 134, DY 4- 154, DY 5-154).

Process Milestones:

In DY 2 we will establish baseline rates for sepsis mortality to measure for improvement targets It is expected that the morality rate for this population in DY 2 will initially increase compared to DY 1 due to more patients being correctly diagnosed with new sepsis protocols thus a baseline will be established in DY2 to measure same mortality based on same standards of care.. IN DY2 and 3 we will conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

Outcome Improvement targets:

By DY 4 and DY5, the improvement target is Sepsis mortality reduction of 20% by the end of the waiver.

Rationale

The process milestone to establish a baseline rate is necessary to understand the starting point for sepsis mortality as defined by protocol in order to measure improvement in DY 4 and DY 5.

The process milestone selected for conducting Plan Do Study Act (PDSA) will implement a continuous quality improvement model consisting of a logical sequence of four repetitive steps for continuous improvement and learning that will assist in the achievement of improvement targets. By turning ideas into action and connecting action to learning we believe PDSA cycles will facilitate change. The process that can be analyzed and measured with data and compared to predicted results will expedite new changes to be implemented in a disciplined fashion in as necessary repetitive cycle.

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. . Each year mortality from severe sepsis and septic shock nationally have consistently been reported to be over 20-25% for severe sepsis

and as high as 70% for septic shock. The outcome target for mortality was selected as evidence based initiatives put in place can reduce mortality. In order to measure the effectiveness of sepsis initiatives mortality rate reduction will be measured

Outcome Measure Valuation

Medical Center of Lewisville Center defined the population that will be directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The population expected to be positively impacted by the project for mortality was 647 which was determined based on outcome target for reduction in mortality by 20% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 17 . The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $198,129 for 5 years.
The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay by 20% from baseline average of 7 days per patient. This was estimated at total of reduced in patient days by DY 5 of 647. The estimated cost per day for a sepsis patient is $930. This totaled approximately $751,905.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $177,100.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 4. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $601,524.

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of mortality reduction at $177,100.
To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $526,333.

The total value of the project then was estimated at $2,431,091. Approximately 79.1% of the total value was assigned to Category 2 project ($1,923,053) and the remaining 10.46% of value

assigned to Category 3 outcome for Sepsis Mortality ($254,518) and 10.46% assigned to Category 3 outcome for reduced Average Length of Stay ($254,520).

094192402.3.2	*3.IT-4.8*	*Sepsis mortality*	
Medical Center of Lewisville			*094192402*
Related Category 1 or 2 Projects::	*094192402.2.2*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients hospitalized with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.* *Target population: patients hospitalized with severe sepsis or septic shock and/or an infection and organ dysfunction.*		
Year 2 (10/1/2012 – 9/30/2013)	**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 <u>Metric 1:</u> Number of patients treated with Sepsis Resuscitation and Management Bundles Goal: Baseline Data Source: EHR Process Milestone 1 Estimated Incentive*:* $14,067 **Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities <u>Metric 1:</u> : Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Initiative Plan Process Milestone 2 Estimated Incentive Payment*:* $14,067	**Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities <u>Metric 1:</u> : Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Initiative Plan Process Milestone 3 Estimated Incentive Payment: $48,917	**Outcome Improvement Target 1** [IT-4.8]: Improvement Target: 15% reduction in mortality from baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $52,330	**Outcome Improvement Target 2** [IT-4.8]: Improvement Target: 20% reduction in mortality from base line Data Source:EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $125,137
Year 2 Estimated Outcome Amount: $28,134	Year 3 Estimated Outcome Amount: $48,917	Year 4 Estimated Outcome Amount: $52,330	Year 5 Estimated Outcome Amount: $125,317
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $254,518			

Title of Outcome Measure (Improvement Target): IT-4.9 Average length of stay

Unique RHP outcome identification number(s): 094192402.3.3

Performing Provider Name/TPI: Medical Center of Lewisville/94192402

Outcome Measure Description

IT-4.9: Average length of stay is the number days a patient is hospitalized when diagnosed with severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl). With earlier diagnosis of sepsis and compliance with Sepsis Resuscitation and Management of care, average length stay should decrease as result. We expect to diagnose and treat 647 sepsis patients (estimated at DY 1- 93, DY2-112, DY 3- 134, DY 4- 154, DY 5-154).

Process Milestones:

In DY 2 we will establish baseline rates for sepsis average length of stay to measure for improvement targets. It is expected that the average length of stay for this population in DY 2 will initially be different compared to DY 1 due to more patients being correctly diagnosed with new sepsis protocols thus a baseline will be established in DY2 to measure length of stay based on same standards of care. IN DY2 and 3 we will conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

Outcome improvement targets:

By DY 4 and DY5, the improvement target is Sepsis average length of stay of 20% by the end of the waiver.

Rationale

The process milestone to establish a baseline rate is necessary to understand the starting point for the average length of stay for patient receiving Sepsis Resuscitation Management Bundle Care in order to measure improvement in DY 4 and DY 5. Typically average length of stay for ICU has been measure but not for the entire hospitalization.

The process milestone selected for conducting Plan Do Study Act (PDSA) will implement a continuous quality improvement model consisting of a logical sequence of four repetitive steps for continuous improvement and learning that will assist in the achievement of improvement targets. By turning ideas into action and connecting action to learning we believe PDSA cycles will facilitate change. The process that can be analyzed and measured with data and compared to predicted results will expedite new changes to be implemented in a disciplined fashion in as necessary repetitive cycle.

The outcome improvement target to reduce length of stay was selected to measure the effectiveness of evidence based care initiatives for sepsis diagnosis and treatment. Average length of stay reduction can also show advancement of sepsis care that is effective through the continuum of the hospital not just in critical care units and comprehensive, coordinated discharge planning.

Outcome Measure Valuation:

Medical Center of Lewisville Center defined the population that will be directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The population expected to be positively impacted by the project for mortality was 647 which was determined based on outcome target for reduction in mortality by 20% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 17. The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $198,129 for 5 years.
The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay by 20% from baseline average of 7 days per patient. This was estimated at total of reduced in patient days by DY 5 of 647. The estimated cost per day for a sepsis patient is $930. This totaled approximately $751,905.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $177,100.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 4. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $601,524.

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of mortality reduction at $177,100.
To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $526,333.

The total value of the project then was estimated at $2,431,091. Approximately 79.1% of the total value was assigned to Category 2 project ($1,923,053) and the remaining 10.46% of value assigned to Category 3 outcome for Sepsis Mortality ($254,518) and 10.46% assigned to Category 3 outcome for reduced Average Length of Stay ($254,520).

094192402.3.3	*3.IT-4.9*	*Average length of stay (Non-standalone measure)*	
Medical Center of Lewisville			*094192402*
Related Category 1 or 2 Projects:	*094192402.2.2*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients hospitalized with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.* *Target population: patients hospitalized with severe sepsis or septic shock and/or an infection and organ dysfunction.*		
Year 2 (10/1/2012 – 9/30/2013)	**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 Metric 1: ALOS for patients treated with Sepsis Resuscitation and Management Bundles Goal: Baseline Data Source: EHR Process Milestone 1 Estimated Incentive Payment *:*$14,068 **Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Improvement Plan Process Milestone 2 Estimated Incentive Payment*:* $14,067	**Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Improvement Plan Process Milestone 3 Estimated Incentive Payment: $48,918	**Outcome Improvement Target 1** [IT-4.9]: Improvement Target: 10% reduction in average length of stay from baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $52,330	**Outcome Improvement Target 2** [IT-4.9]: Improvement Target: 20% reduction in average length of stay from baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $125,317
Year 2 Estimated Outcome Amount: $28,135	Year 3 Estimated Outcome Amount: $48,918	Year 4 Estimated Outcome Amount: $52,330	Year 5 Estimated Outcome Amount: $125,137
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $254,520			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization

Unique RHP outcome identification number(s): 094192402.3.4

Performing Provider Name/TPI: Medical Center of Lewisville/094192402

Outcome Measure Description

The outcome measure is to reduce ED visits for those patients who are part of Patient Navigation program. The target for the outcome is to reduce ED visits for these patients by 65 % which equates to a 15% overall ED visit reduction by the end of the waiver period.

Process Milestone:

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. It will also be necessary establish a base line rate for ED Visits in order to correctly measure the reduction for those patients specifically enrolled in the navigation program. In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders.

Outcome Improvement targets for each year:

Our goal is to reduce the inappropriate ED visits of the target popualtion by 65 % by DY5. It is estimated the ED visits by target population if continued at 5.77 per year are DY3-1,875 DY4-3,375 DY5-4,876. With an effective patient navigation program we anticpate the ED visits from patients in the patient navigation program will be reduced to DY3, -650, DY4-1,170 DY5-1,690, a reduction of 6,616 visits. The overall ED visits baseline is 43,000 visits per year, a reduction of 6,616 is an overall reduction in ED visits of 15% by DY 5,(DY3-3%, DY4 -5%, DY5-7%).

Rationale

The process milestone to establish the baseline rate is necessary to understand the starting point of patients to focus on. Various data points from both internal and external reporting vary and it will be necessary to ensure the defined population is known so targeted interventions are addressed. The outcome improvement targets were selected as they are congruent with other goals of the organization and will result in improved health outcome of patients and reduce cost to the health system.

The target for the outcome measure to reduce ED visits by 15% by the of the waiver period. We have implemented initiatives to reduce ED visits (i.e. improved discharge planning, etc) but the patients continue to utilize ED as primary medical home. We believe a renewed focus is necessary to make significant reductions in rate of ED utilization by patients.

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders (IP /OP, out of hospital providers, etc) are identified and included in the plan. Indentifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan is a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.

It will also be necessary in DY 2 to establish a base line rate for ED utilization in order to correctly measure a rate reduction for those patients eligible for patient navigation. We have estimated the number of patients with visits > 4 times a year and a % of those patients who will be eligble (DY3-25%, DY4-45%, DY5-65%). The process milestone to establish the baseline rate is necessary to understand the starting point of patients to focus once patient navigation criteria are established. Various data points from both internal and external reporting vary and it will be necessary to ensure the defined population is known so targeted interventions are addressed. In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This would include intervention impacts, learning from follow up on successes or failures and identified best practices. This feedback is significant to adjusting plans findings and continued engagement of stakeholders.

Outcome Measure Valuation

In valuing our projects we took into account direct patient ED cost and resources needed to impact the measure.

Medical Center of Lewisville recognized that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, the project and outcomes was computed with a total value of the Category 3 outcomes connected to each project. Medical Center of Lewisville estimated the ED visits by target population if continued at 5.77 per year are DY3-1,875 DY4-3,375 DY5-4,876. With an effective patient navigation program we anticipate the ED visits from patients in the patient navigation program will be reduced to DY3, -650, DY4-1,170 DY5-1,690, a reduction of 6,616 visits. DY3, -650, DY4-1,170 DY5-1,690, a reduction of 6,616 visits. The average, direct cost of an ED visit from internal cost information is $250 per visit so for DY 3-5 cost saved would be $1,654,300. The patient navigation program, 4 year costs for the waiver period were estimated at $704,000. This cost included direct staff hired to run the navigation program (1-2 RN/case managers) and 10% overhead for management time and additional costs (transportation, interpreters, etc.). The total net value was $950,300 ($1,654,300 less $704,000). Approximately 79.06% of the total value was assigned to Category 2 project ($751,402) and the remaining 20.93% of value assigned to Category 3 outcome for reduction of ED visits ($198,898).

Rationale/Justification: The outcome improvement targets are dependent on the target population served size and also processes to be put in place to achieve the target..

094192402.3.4	*3 IT-9.2*	*ED appropriate utilization*	
Medical Center of Lewisville			*094192402*
Related Category 1 or 2 Projects::	*094192402.2.3*		
Starting Point/Baseline:	*Target population of patients utilize ED > 3 times 12 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)**
Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans] Metric 1: submission of plan Goal: Plan Data Source: ED Improvement Plan Process Milestone 1 Estimated Incentive Payment *:* $10,993 **Milestone 2** [P- 2]:Establish baseline rates Metric 1: Number of patients with > 4visits to ED eligible for patient navigation Goals: baseline Data Source: ED Improvement Plan Process Milestone 2 Estimated Incentive Payment *:* $10,993	**Milestone 3** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: submission of documentation of findings and communication Goal: stakeholder meetings Data Source: ED Improvement Plan Process Milestone 3 Estimated Incentive Payment: $38,228	**Outcome Improvement Target 1** [IT-3.2]: Improvement Target:8 % reduction over baseline in ED Visits Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $40,894	**Outcome Improvement Target 2** [IT-3.2]: Improvement Target: 15% reduction over baseline in ED Visits Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $97,790
Year 2 Estimated Outcome Amount: $21,986	Year 3 Estimated Outcome Amount: $38,228	Year 4 Estimated Outcome Amount: $40,894	Year 5 Estimated Outcome Amount: $97,790
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $198,898			

Title of Outcome Measure (Improvement Target): IT-4.10 Treatment Rate Ischemic Stroke (IV t-PA)

Unique RHP outcome identification number(s): 020943901.3.1

Performing Provider Name/TPI: Medical City Dallas/020943901

Outcome Measure Description

The outcome measure is to increase the Treatment rate for Ischemic Stroke patients by IV t-PA.. An acute stroke is a medical emergency and is the leading cause of disability in the United States. Approximately 1.9 million brain cells die every minute during an acute stroke. Timely diagnosis and initiation of treatment is essential to good outcomes. Getting this medication to appropriate patients as quickly and as safely as possible ensures that patients have the best chance at an optimal outcome. When patients present to the Emergency Room, physicians must assess the first onset of symptoms. IV tPA is the only FDA approved treatment for ischemic stroke patients in first 4.5 hours from first onset of symptoms to restore blood flow in the brain. The IV tPA is adminstered via IV to dissolve the blot clot causing the stroke. If a patient presents > 4.5 hours from first symptom, they can be assessed to see if they qualify for comphrensive treatment (endovascular treatments) but the window has closed on the IV tPA treatment opportunity. The quicker blow flow is restored the great chance of good outcomes. Once Emergency Room phsycians have access to neuro specialists, they have assistance in the decision making process to use intravenous (IV) thrombolysis with tissue plasominogen activator (tPA). However it is still the Emergency Rooms physicians' education ,assessment and his/her willingness to use IV tPA for eligible patients that drives the ultimate use of the treatment option. Barriers to using IV tPA include risk of futher bleeding and death. Over time with the telestroke network access and education we believe we can increase treatment rates. By increasing the number of patients that are treated with IV t-PA we can prevent or decrease the patient's chance of permanent and/or long term disability. The target for the outcome measure is to improve the rate of IV tPA treatment for the targeted population by 15 % by end of the waiver period

Process Milestone:

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. It will also be necessary establish a base line treatment rate in order to correctly measure a rate improvement. In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders.
The process milestone to establish the baseline rate is necessary to understand the starting point of treatment rates for stroke. The outcome improvement targets were selected as they are congruent with other goals of the organization and will result in improved health outcome of patients and reduce cost to the health system.

Outcome improvement targets:

In DY 4, we will improve the treatment rate for stroke patients by 10%. In DY5, we will improve the rate to15%.

Rationale

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders are identified and included in the plan. Identifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan is a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.

It will also be necessary in DY 2 to establish a base line rate treatment rate in order to correctly measure the improvement. The process milestone to establish the baseline rate is necessary to understand the starting point of patient population for stroke patients consult for treatment. Also an assessment will be conducted to assess patients at remote sites for which a telemedicine consult would be appropriate.

In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This would include intervention impacts, learning from follow up on successes or failures and identified best practices. This feedback is significant to adjusting plans findings and continued engagement of stakeholders.

The outcome improvement target of increasing the Treatment Rate of Stroke patient will measure effectiveness of protocols and training of telemedicine stroke program implemented. With an effective program, access to specialty care and availability of treatment options will improve.

Outcome Measure Valuation

Medical City Dallas defined the population that will be directly impacted by the project as patients receiving a neuro-specialist consult. To provide these consults, neuro-specialists will need to be secured and available 24/7 for 40 additional sites. The estimate value is $1,092,000 for 4 years of the project based on minimum 30 minute time per consult valued at $78 each - annual income of specialist 650k year and volumes ,DY2-2000,DY3-3000, DY4-4000, DY5-5000. It will be necessary to continue to train physicians and staff on stroke protocols, treatment and use of technology. This is estimated at $183,00 per year for 4 years for a total value of $732,000.
It is also projected a 15% Treatment Rate for IV tPA in targeted population will result in less disability or severe disability in patients. We estimate 25% of the patients will be eligible for IV tPA (3500 patients, DY2-500, DY3 -750, DY4-1000, DY5-1250) and treatment rate at 15% by DY 5, total 365 patient would receive treatment who would not have otherwise(DY2-25, DY3-52,

DY4-100, DY5-188). Of these 120 patients, 33% would have not long term disability bases on trial studies (DY2-8, DY3-17,DY4-33,DY5-62). It is estimated based on a British study, annual direct cost of disabled stroke patients and lost productivity was $30,600, for a total of $3,672,000.
In addition, length of stay will be reduced for stroke patients. We estimate this to be approximately 945 days with internal cost estimates per day of $1,000. This is a total value of $945,000.
The remainder of $23,085 for total value was reduced to balance total funding.

The total value of the project then was estimated at $6,417,915. Approximately 80.62% of the total value was assigned to Category 2 project ($5,174,491) and the remaining value was assigned to Category 3 outcomes 6.46% IV TPA Treatment Rate ($414,470), 6.46% for Average Length of Stay ($414,471) and 6.46% for Door To Needle Time ($414,483.

020949301.3.1	*3.IT-4.10*	*IV tPA Treatment Rate for Stroke Patients*	
Medical City Dallas			*020943901*
Related Category 1 or 2 Projects:	*020943901.1.1*		
Starting Point/Baseline:	*Identify all patients presenting to emergency room for stroke treatment with consult*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans] Metric 1: submission of telemedicine plan Goal: Plan Data Source Telestroke Improvement Plan Process Milestone 1 Estimated Incentive Payment *:* $23,964 **Process Milestone 2** [P- 2]: Establish baseline rates Metric 1: Number of patients present to ED with stroke consult Goal: Baseline Data Source: Assessment plan Process Milestone 2 Estimated Incentive Payment *:* $23,965	**Process Milestone 3** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: submission of documentation of findings and communication Goal: Stakeholder meetings Data Source: Telestroke Improvement Plan Process Milestone 3 Estimated Incentive Payment: $56,411	**Outcome Improvement Target 1** [IT-4.10]: Improvement Target: 10% IV tPA Treatment rate Data Source: Telestroke Data base Numerator: Total patients treated with IV tPA Denominator: Total patients eligible for IV tPA treatment Outcome Improvement Target 1 Estimated Incentive Payment*:* $90,520	**Outcome Improvement Target 2** [IT-4.10]: Improvement Target: 15% IV tPA Treament Rate Data Source: Telestroke Database Numerator: Total patients treated with IV tPA Denominator: Total patients eligible for IV tPA treatment Outcome Improvement Target 2 Estimated Incentive Payment*:* $219,610
Year 2 Estimated Outcome Amount: $47,929	Year 3 Estimated Outcome Amount: $56,411	Year 4 Estimated Outcome Amount: $90,520	Year 5 Estimated Outcome Amount: $219,610
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $414,470			

Title of Outcome Measure (Improvement Target): IT-4.10 Average Length of Stay (Stroke Patients)

Unique RHP outcome identification number(s): 020943901.3.2

Performing Provider Name/TPI: Medical City Dallas/020943901

Outcome Measure Description:

The outcome measure is to reduce average length of stay (LOS) by increasing treatment rates and decreasing unnecessary transfers. The goal is to decrease LOS by 10% of the overall ischemic stroke population in targeted population.

Process Milestones:

The target for the outcome measure is to reduce the rate by 10% by the end of the waiver period. In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. It will also be necessary establish a base line rate for readmissions in order to correctly measure a rate reduction. In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders.
The process milestone to establish the baseline rate is necessary to understand the starting point of patients ALOS and variables contributing to ALOS (ICU, discharge planning barriers, rehabilitation need, etc).

Outcome improvement targets:

The outcome improvement targets were selected as they are congruent with other goals of the organization and will result in improved health outcome of patients and reduce cost to the health system.

In DY 4, the target is to reduce ALOS for stroke patients by 5% from baseline. In DY 5, reduction is targeted at 5%. By the end of the waiver period we will have achieved a 10% reduction. Increased access to specialist is necessary to make appropriate stoke treatment available and significant reductions in ALOS.

Rationale

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders are identified and included in the plan. Identifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan is a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.

It will also be necessary in DY 2 to establish a base line rate for admissions in order to correctly measure a rate reduction. The process milestone to establish the baseline rate is necessary to understand the starting point of patients population ALOS of stroke patients that received a consult and treatment. Also an assessment will be conducted to assess patients at remote sites for which a telemedicine consult would be appropriate.

In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This would include intervention impacts, learning from follow up on successes or failures and identified best practices. This feedback is significant to adjusting plans findings and continued engagement of stakeholders.

The outcome target for average length stay was selected as a measurement of effective stroke program. With evidence based care for stroke, average length of stay should decrease.

Outcome measure valuation:

Medical City Dallas defined the population that will be directly impacted by the project as patients receiving a neuro-specialist consult. To provide these consults, neuro-specialists will need to be secured and available 24/7 for 40 additional sites. The estimate value is $1,092,000 for 4 years of the project based on minimum 30 minute time per consult valued at $78 each - annual income of specialist 650k year and volumes ,DY2-2000,DY3-3000, DY4-4000, DY5-5000. It will be necessary to continue to train physicians and staff on stroke protocols, treatment and use of technology. This is estimated at $183,00 per year for 4 years for a total value of $732,000.
It is also projected a 15% Treatment Rate for IV tPA in targeted population will result in less disability or severe disability in patients. We estimate 25% of the patients will be eligible for IV tPA (3500 patients, DY2-500, DY3 -750, DY4-1000, DY5-1250) and treatment rate at 15% by DY 5, total 365 patient would receive treatment who would not have otherwise(DY2-25, DY3-52, DY4-100, DY5-188). Of these 120 patients, 33% would have not long term disability bases on trial studies (DY2-8, DY3-17,DY4-33,DY5-62). It is estimated based on a British study, annual direct cost of disabled stroke patients and lost productivity was $30,600, for a total of $3,672,000.
In addition, length of stay will be reduced for stroke patients. We estimate this to be approximately 945 days with internal cost estimates per day of $1,000. This is a total value of $945,000.
The remainder of $23,085 for total value was reduced to balance total funding.

The total value of the project then was estimated at $6,417,915. Approximately 80.62% of the total value was assigned to Category 2 project ($5,174,491) and the remaining value was assigned to Category 3 outcomes 6.46% IV TPA Treatment Rate ($414,470), 6.46% for Average Length of Stay ($414,471) and 6.46% for Door To Needle Time ($414,483.

020949301.3.2	*3.IT-4.10*	*Average Length of Stay*	
Medical City Dallas			*020943901*
Related Category 1 or 2 Projects::	*020943901.1.1*		
Starting Point/Baseline:	*Identify all patients presenting to emergency room for stroke treatment with consult*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans] Metric 1: submission of telemedicine plan Goal: Plan Data Source Telestroke Improvement Plan Process Milestone 1 Estimated Incentive Payment *:* $23,964 **Process Milestone 2** [P- 2]: Establish baseline rates Metric 1: Average length of stay ischemic stroke patients Goal: Baseline estimated 5.0 ALOS Data Source: EHR, Telestroke Improvement plan Process Milestone 2 Estimated Incentive Payment *:* $23,965	**Process Milestone 3** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: submission of documentation of findings and communication Goal: Stakeholder meetings Data Source: Telestroke Improvement Plan Process Milestone 3 Estimated Incentive Payment: $56,411	**Outcome Improvement Target 1** [IT-4.10]: Improvement Target:5% reduction over baseline in Average Length of Stay Data Source: Telestroke Data base, EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $90,521	**Outcome Improvement Target 2** [IT-4.10]: Improvement Target: 10% reduction over baseline in Average Length of Stay Data Source: Telestroke Database, EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $219,610
Year 2 Estimated Outcome Amount: $47,929	Year 3 Estimated Outcome Amount: $56,411	Year 4 Estimated Outcome Amount: $90,521	Year 5 Estimated Outcome Amount: $219,610
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $414,471			

Title of Outcome Measure (Improvement Target): IT-4.10 Door to Needle time for IV t-PA administration

Unique RHP outcome identification number(s): 020943901.3.3

Performing Provider Name/TPI: Medical City Dallas/020943901

Outcome Measure Description:

The outcome measure is improve the time from patient presenting to hospital to diagnosing and treating stroke patient with appropriate IV t-PA. An acute stroke is a medical emergency. Approximately 1.9 million brain cells die every minute during an acute stroke. Timely diagnosis and initiation of treatment is essential to good outcomes. Getting this medication to appropriate patients as quickly and as safely as possible ensures that patients have the best chance at an optimal outcome. When patients present to the Emergency Room, physicians must assess the first onset of symptoms. IV tPA is the only FDA approved treatment for ischemic stroke patients in first 3-4.5 hours from first onset of symptoms to restore blood flow in the brain. The IV tPA is adminstered via IV to dissolve the blood clot causing the stroke. The quicker blood flow is restored the greater chance of good outcomes. Some researchers estimate that among 100 patients given tPA within the 3 to 4.5-hour treatment window, every 10-minute delay in the start of therapy reduces by 1 the number of patients having an improved disability outcome. The IV tPA drug is strongly time dependent. The efficacy of the drug over time in dissolving the clot decreases dramatically and patients may not benefit.
Since eligible patients are presenting to the ED anywhere within 4.5 hours of first symptoms, the window of effective IV tPA treatment time can be limited. The specialty consult, testing (CT, etc) and diagnosis must be done quickly. The total IV tPA treatment time itself can take anywhere from as low as 20 minutes to a long as 60 minutes to complete. Thus a time standard has been established for time patient presents (Door) to the time IV tPA treatment begins (Needle). This measures the efficiency and effectiveness of stroke protocols put in place to triage, diagnose and treat or other disposition (transfer, no treat) of patients. The American Stroke Association (ASA) has set the quality measure/target for initiating this life saving treatment at 60 minutes upon patient arrival. The target for the outcome measure is to improve TBD by the end of the waiver period

Process Milestones:

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. It will also be necessary establish a base line rate for readmissions in order to correctly measure a rate reduction. In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders.

Outcome Improvement Targets for each year

In DY 4, we will improve to Door to Needle time by 10 %. In DY 5 the target will improve 10 %.

Rationale

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders are identified and included in the plan. Identifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan is a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.

It will also be necessary in DY 2 to establish a base line rate for door to needle time in order to correctly measure a rate reduction. The process milestone to establish the baseline rate is necessary to understand the starting point for treatment of stroke patients with a consult for treatment. Also an assessment will be conducted to assess patients at remote sites for which a telemedicine consult would be appropriate.

In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This would include intervention impacts, learning from follow up on successes or failures and identified best practices. This feedback is significant to adjusting plans findings and continued engagement of stakeholders.

The outcome target to reduce /improve the Door to Needle Time will measure effectiveness of telestroke program elements for quick access to consults timeliness of consult delivery, effectiveness of consult to begin life saving treatment within 60 minutes of arrival.

Project Valuation

Medical City Dallas defined the population that will be directly impacted by the project as patients receiving a neuro-specialist consult. To provide these consults, neuro-specialists will need to be secured and available 24/7 for 40 additional sites. The estimate value is $1,092,000 for 4 years of the project based on minimum 30 minute time per consult valued at $78 each - annual income of specialist 650k year and volumes ,DY2-2000,DY3-3000, DY4-4000, DY5-5000. It will be necessary to continue to train physicians and staff on stroke protocols, treatment and use of technology. This is estimated at $183,00 per year for 4 years for a total value of $732,000.

It is also projected a 15% Treatment Rate for IV tPA in targeted population will result in less disability or severe disability in patients. We estimate 25% of the patients will be eligible for IV tPA (3500 patients, DY2-500, DY3 -750, DY4-1000, DY5-1250) and treatment rate at 15% by DY 5, total 365 patient would receive treatment who would not have otherwise(DY2-25, DY3-52, DY4-100, DY5-188). Of these 120 patients, 33% would have not long term disability bases on trial studies (DY2-8, DY3-17,DY4-33,DY5-62). It is estimated based on a British study, annual direct cost of disabled stroke patients and lost productivity was $30,600, for a total of $3,672,000.

In addition, length of stay will be reduced for stroke patients. We estimate this to be approximately 945 days with internal cost estimates per day of $1,000. This is a total value of $945,000.
The remainder of $23,085 for total value was reduced to balance total funding.

The total value of the project then was estimated at $6,417,915. Approximately 80.62% of the total value was assigned to Category 2 project ($5,174,491) and the remaining value was assigned to Category 3 outcomes 6.46% IV TPA Treatment Rate ($414,470), 6.46% for Average Length of Stay ($414,471) and 6.46% for Door To Needle Time ($414,483.

020949301.3.3	*3.IT-4.10*	*Door to Needle Time IV t-PA administration*	
Medical City Dallas			*020943901*
Related Category 1 or 2 Projects::	*020943901.1.1*		
Starting Point/Baseline:	*Identify all patients presenting to emergency room for stroke treated with IV tPA*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans] Metric 1: submission of telemedicine plan Goal: Plan Data Source Telestroke Improvement Plan Process Milestone 1 Estimated Incentive Payment *:* $23,964 **Process Milestone 2** [P- 2]: Establish baseline rates Metric 1: Door to needle time for IV t-PA administration estimated 70 minutes Goal :perform retrospective analysis of cases Data Source: EHR, Telestroke Improvement Plan Process Milestone 2 Estimated Incentive Payment *:* $23,964	**Process Milestone 3** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: Submission of documentation of findings and communication Goal: Stakeholder meetings Data Source: Telestroke Improvement Plan Process Milestone 3 Estimated Incentive Payment: $56,411	**Outcome Improvement Target 1** [IT-4.10]: Improvement Target: 10% reduction over baseline for Door to Needle Time Data Source: EHR, Telestroke Data base Outcome Improvement Target 1 Estimated Incentive Payment*:* $90,520	**Outcome Improvement Target 2** [IT-4.10]: Improvement Target: 20% reduction over baseline for Door To Needle Time Data Source: EHR, Telestroke Database Outcome Improvement Target 2 Estimated Incentive Payment*:* $219,624
Year 2 Estimated Outcome Amount: $47,928	Year 3 Estimated Outcome Amount: $56,411	Year 4 Estimated Outcome Amount: $90,520	Year 5 Estimated Outcome Amount: $219,624
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $414,483			

Title of Outcome Measure (Improvement Target): IT-2.4 Behavioral Health/ Substance Abuse (BH/SA) Admission Rate

Unique RHP outcome identification number(s): 020943901.3.4

Performing Provider Name/TPI: Medical City Dallas/020943901

Outcome Measurement Description:

The outcome measure is to reduce preventable admissions to hospitals for those patients that with a Behavioral Health or Substance Abuse primary diagnosis or when a significant secondary diagnosis. The rate is defined as a total of adult discharges for Behavioral health/substance abuse as primary diagnosis and significant secondary diagnosis as a percent of total adult population in the region. We estimate based on market data the rate in the region is .505% currently.
The target for the outcome measure is to reduce the regional rate by 1%by the end of the waiver period. We are currently focused on a baseline of admission from telemedicine sites of 304. It is estimated these admission will be reduced by DY 2-5%, DY 3-15%, 15% in DY 4 and 15% in DY5 for a total of 50% reduction from baseline, of 152 admissions. This outcome measure has also been selected for project 020943901.2.1 (outcome 020943901.3.6). The outcome target for 020943901.3.4 is the measure of admission reduction specifically originating from Emergency rooms for lack of psychiatric specialty care. Project 020943901.2.1, (outcome 020943901.3.6) will measure the reduction in admissions resulting from improved access to medical care with integrated primary and behavioral care. Both projects are expected to impact Behavioral Health/Substance Abuse admissions but will impact different causes of the admission (lack of primary care/medical care or specialty care access).

Process Milestones

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. It will also be necessary establish a base line rate for admissions in order to correctly measure a rate reductionThe focus is on patient with medical issues who are not receiving care, thus we will establish baseline for patients without primacy care access. In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders from the baseline analysis and development of Behavioral Health admission Improvement Plan

Outcome improvement targets

In DY 4, we expected to reduce the admission rate by .5% and in DY 5, another .5% reduction from baselinefor a total of 1% reduction from baseline.

Rationale

The process milestone to establish the baseline rate is necessary to understand the target patient population. Various data points from both internal and external reporting vary and it will be necessary to ensure the defined population is known so targeted interventions are addressed. The outcome improvement targets were selected as they are congruent with other goals of the organization and will result in improved health outcome of patients and reduce cost to the health system.

The target for the outcome measure admission rate is to reduce the rate by 1% by the end of the waiver period. Increased access to specialists is necessary to make significant reductions in the admission rate.

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders are identified and included in the plan. Identifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan is a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.

It will also be necessary in DY 2 to establish a base line rate for admissions in order to correctly measure a rate reduction. The process milestone to establish the baseline rate is necessary to understand the starting point of patients to focus on. We have primary diagnosis data analyzed but significant secondary diagnosis will need to be identified and a baseline established. Also an assessment will be conducted to see patients for which a telemedicine consult would be appropriate.

In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This would include intervention impacts, learning from follow up on successes or failures and identified best practices. This feedback is significant to adjusting plans findings and continued engagement of stakeholders.

Outcome Measure Valuation

The economic value of each targeted improvement outcome from evidence based studies was used a guide for the overall value of project. Additional value was considered for resource investments needed, timelines, cost avoidance, community benefit and risk and project scope. Medical City Dallas defined the population that will be directly impacted by the project as patients receiving a psychiatric consult. To provide these consults, psychiatric specialists will need to be secured and available 24/7. The estimate value is $1,825,000 for 5 years of the project based on daily value of $1,000. Additional 5 year values for resources needed for the project include 1) administrator $500,000 2) staff $300,000, 3) IT equipment , IT resources and IT lines $800,000, and 4) training and education $183,000. In addition, it is projected 152

Behavioral Health/Substance abuse admission will be avoided. These are valued at $285,456 based on internal cost per admission of $1,878.
An additional 15% value was added for overhead for administering the program (CEO time, Medical staff etc.), $541,200.
The remainder of $36,622 for total value was added to balance total funding.
Another approach for project value was reviewed based on estimated DY3, DY 4 and DY 5 additional capacity from timely discharge resulting from telemedicine consults (DY3-1500, DY 4-2300, DY5-2400). We estimated additional visits of 12,400 were would be possible from decreased holding and turn around time for ED visits. We used the average contribution margin for Medicaid visit from internal data of $360/ per visit for a total of $4,464,000. We believe this supports the overall valuation of $4,471,278.

The total value of the project then was estimated at $4,471,278. Approximately 80.65% of the total value was assigned to Category 2 project ($3,606,157) and the remaining 19.34% of value assigned to Category 3 outcome for Behavior Health/Substance abuse Admission Rate ($865,121).

020943901.3.4	*3.IT-2.4*	*Behavioral Health/Substance Abuse (BH/SA) Admission Rate*	
Medical City Dallas			*020943901*
Related Category 1 or 2 Projects:	*020943901.1.2*		
Starting Point/Baseline:	*Identify all patients with Behavioral Health and Substance abuse primary diagnosis and significant secondary diagnosis at remote telemedicine sites*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: submission of plan of telemedicine plan Goal: Plan Data Source: Behavioral Health admission Improvement Plan Process Milestone 1 Estimated Incentive Payment: $50,024 **Process Milestone 2** [P- 2]: Establish baseline rates Metric 1: Number of patients in need of behavioral health consult who are admitted Goal: Baseline Data Source: Behavioral Health admission Improvement Plan Process Milestone Estimated Incentive Payment: $50,024	**Process Milestone 3** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: submission of documentation of findings and communication Goal: Stakeholder meetings Data Source Behavioral Health admission Improvement Plan Process Milestone 3 Estimated Incentive Payment: $117,746	**Outcome Improvement Target 1** [IT-2.4]: Improvement Target.5%5% reduction from baseline BH/SB Admission Rate for principal diagnosis and secondary diagnosis Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $188,940	**Outcome Improvement Target 2** [IT-2.4]: Improvement Target:1% reduction from baseline for BH/SB Admission Rate for principal diagnosis and secondary diagnosis Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $458,387
Year 2 Estimated Outcome Amount: $100,048	Year 3 Estimated Outcome Amount: $117,746	Year 4 Estimated Outcome Amount: $188,940	Year 5 Estimated Outcome Amount: $458,387
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $865,121			

Title of Outcome Measure (Improvement Target): IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits - NQF 1381

Unique RHP outcome identification number(s): 020943901.3.5

Performing Provider Name/TPI: Medical City Dallas/020943901

Outcome Measurement Description:

The outcome measure is to reduce emergency room visits from pediatric/young adult asthma patients with primary and secondary diagnosis. The target for the outcome measure is to reduce visit rate by 35% by the end of the waiver.

Process Milestones:

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. It will also be necessary establish a base line rate for asthma ED visits in order to correctly measure a rate reduction. Based on current measurements we estimate there are 1,100 Pediatric asthma ED visits per year, of which 65% are Medicaid eligible and indigent. Current estimates may not be based on same defined (age and diagnosis) as required, so a baseline will be developed in DY 2. The target population will be Medicaid and indigent patients, 715 patients. In DY 3, we will test and develop data systems for referrals, tracking patients with asthma and primary care medical home.

Outcome improvement targets:

In DY 3-5 we will begin to measure and report the rate and improvement target of a DY3-5% ,DY4-15%, DY5- 15% for a total 35% reduction from total baseline visits of 1100. (DY3-55, DY4-165- DY5-165) We expected to reduce the rate of Medicaid and indigent patients (715 visit a year) by 55%,385 visit per year (which 35% of total visits,1100).

Rationale

The process milestone to establish the baseline rate is necessary to understand the starting point of patients to focus on. Various data points from both internal and external reporting vary and it will be necessary to ensure the defined population is known so targeted interventions are addressed. The outcome improvement targets were selected as they are congruent with other goals of the organization and will result in improved health outcome of patients and reduce cost to the health system.

The target for the outcome measure pediatric/young adult emergency room visits is to reduce the rate by 35% by the end of the waiver period. This outcome improvement will measure initiatives in new clinic for chronic care management.

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders (IP /OP, out of hospital providers, etc) are identified and included in the plan. Identifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan is a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.

It will also be necessary in DY 2 to establish a base line rate for emergency room visits in order to correctly measure a rate reduction. The process milestone to establish the baseline rate is necessary to understand the starting point of patients to focus on. Various data points from both internal and external reporting vary and it will be necessary to ensure the defined population is known so targeted interventions are addressed. Additional data points necessary include zip codes of targeted population, primary care/medical home status and family and social support network. In DY 3 -5, we will be reporting on the target improvement measure.

Outcome Measure Valuation

The economic value of each targeted improvement outcome obtained from evidence based studies was used a guide for the overall value of projectMedical City Dallas defined the population that will be directly impacted by the project as patients receive a medical home at the pediatric clinic and those patients with pediatric asthma. There were 2 measures used for this project valuation, patient provided a medical home and pediatric/young adult emergency room visits. The population expected to be positively impacted by the project for primary care and medical home is 3,000 patients by DY 5 (DY3-1000, DY 4-2000, DY5- 3000). The estimated pricing for medical home was $650 per year per patient. This value was obtained from averages of various PCMH studies (Intermountain Healthcare, Blue Cross Blue Shield, etc.) The value is based on investing in primary care patient centered medical homes resulting in improved quality of care and patient experiences and costs compared to non-PCMH patients and reductions in expensive hospital and emergency department utilization. This totaled approximately $3,900,000 for 5 years.
The population expected to be positively impacted by the project for reduction in pediatric/young adult asthma patients is 385 visits by DY 5. The estimated cost for a pediatric/young adult ED visits from internal data is $1210. This totaled approximately $465,850

The remainder of $1,896 for total value was added to balance total funding.
The total value of the project then was estimated at $4,367,746. Approximately 80.63% of the total value was assigned to Category 2 project ($3,521,529) and the remaining 19.37% of value assigned to Category 3 outcome for Pediatric/Young Adult ED Visits ($846,217).

020943901.3.5	*3.IT-9.3*	*Pediatric/Young Adult Asthma Emergency Department Visits- NQF*	
Medical City Dallas			*020943901*
Related Category 1 or 2 Projects:	*020943901.1.3*		
Starting Point/Baseline:	*Pediatric/Young adults with asthma presenting to ED, Baseline will be established in DY 2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: submission of project plans Goal: Plan Data Source: Pediatric Clinic Project Plan Process Milestone 1 Estimated Incentive Payment *:* $48,931 **Process Milestone 2** [P-2]: Establish baseline rates Metric 1: number of patients (pediatric/young adult) ED visits Goal: Baseline established and defined, and measured Data Source: EHR, claims data Process Milestone 2 Estimated Incentive Payment: $48,931	**Process Milestone 3** [P-4]: Develop and test data systems Metric 1: Number of systems tested Metric 2: number of systems developed Goal: complete all steps in development and testing Data Source: EHR, Pediatric Project Plan Process Milestone 3 Estimated Incentive Payment: $57,586 **Outcome Improvement Target 1** [IT-1.1]: Improvement Target: Reduce by 5 % from baseline number of pediatric/young adult asthma ED visits Data Source: EHR, claims data Outcome Improvement Target 1 Estimated Incentive Payment*:* $57,586	**Outcome Improvement Target 2** [IT-1.1]: Improvement Target: Reduce by 20% from baseline number of pediatric/young adult asthma ED visits Data Source: EHR, claims data Outcome Improvement Target 2 Estimated Incentive Payment*:* $184,812	**Outcome Improvement Target 3** [IT-1.1]: Improvement Target: Reduce by 35%from baseline baseline number of pediatric/young adult asthma ED visits Data Source: EHR, claims data Improvement Target: Data Source: Outcome Improvement Target 3 Estimated Incentive Payment*:* $448,371
Year 2 Estimated Outcome Amount:: $97,862	Year 3 Estimated Outcome Amount: $115,172	Year 4 Estimated Outcome Amount: $184,812	Year 5 Estimated Outcome Amount: $448,371
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $846,217			

Title of Outcome Measure (Improvement Target): IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate

Unique RHP outcome identification number(s): 020943901.3.6

Performing Provider Name/TPI: Medical City Dallas/020943901

Outcome Measure Description

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

The outcome measure is to reduce preventable admissions to hospitals for those patients that with a Behavioral Health or Substance Abuse primary diagnosis or when a significant secondary diagnosis. The rate is defined as a total of adult discharges for Behavioral health/substance abuse as primary diagnosis and significant secondary diagnosis as a percent of total adult population in the region. We estimate based on market data the rate in the region is .505% currently.
The target for the outcome measure is to reduce the rate by 1.3% by the end of the waiver period.

The selection of outcome measure is to reflect the effectiveness of integrating primary and behavioral care.. By integrating care for patient currently seeking psychiatric care, we believe the rate of admission will be reduced as coordinated care will address whole person as patients with serious mental disorders will receive treatment for medical and physical issues.. This outcome measure has also been selected for project 020943901.1.2 (outcome 020943901.3.4).The outcome target for 020943901.3.4 is the measure of admission reduction specifically originating from Emergency rooms for lack of psychiatric specialty care. This outcome for project 020943901.2.1, (outcome 020943901.3.6) will measure the reduction in admissions resulting from improved access to medical care with integrated primary and behavioral care. Both projects are expected to impact Behavioral Health/Substance Abuse admissions but will impact different causes of the admission (lack of primary care/medical care or specialty care access).

Process Milestones

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. It will also be necessary establish a base line rate for admissions in order to correctly measure a rate reduction. In DY 3, we will disseminate findings, including lessons learned and best practices of admission protocols, to stakeholders to include ER physicians and psychiatrists.

The process milestone to establish the baseline rate is necessary to understand the starting point of patients to focus on. Various data points from both internal and external reporting vary

and it will be necessary to ensure the defined population is known so targeted interventions are addressed.

Outcome Improvement Targets for each year

We estimate an admit rate of 35% on behavioral health diagnosis in ED which results in target population of admissions to reduce of 875. We will reduce admissions for targeted population by 230 by the end of the waiver (DY2-3%, DY3-7%, DY4-15%, DY5-26%) We will reduce the regional rate of admission by DY5 by 1.3 %. The outcome improvement targets were selected as they are congruent with other goals of the organization and will result in improved health outcome of patients and reduce cost to the health system.

Rationale

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders are identified and included in the plan. Identifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan is a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.
It will also be necessary in DY 2 to establish a base line rate for behavioral health/ substance abuse admissions in order to correctly measure a rate reduction. The process milestone to establish the baseline rate is necessary to understand the starting point of patients to focus on. We have primary diagnosis data analyzed but significant secondary diagnosis will need to be identified and a baseline established. Also an assessment will be conducted to see patients for which a telemedicine consult would be appropriate.

In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This would include intervention impacts, learning from follow up on successes or failures and identified best practices. This feedback is significant to adjusting plans findings and continued engagement of stakeholders.

Outcome Measure Valuation

The economic value of each targeted improvement outcome obtained from evidence based studies was used a guide for the overall value of project. Additional value was considered for resource investments needed, timelines, cost avoidance, community benefit, risks and project scope.
Medical City Dallas defined the population that will be directly impacted by the project as patients receive a primacy care medical home at the integrated primary care and behavioral care clinic.. The population expected to be positively impacted by the project for primary care and medical home is 2,500 patients by DY 5. The estimated pricing for medical home was $650

per year per patient. This value was obtained from averages of various PCMH studies (Intermountain Healthcare, Blue Cross Blue Shield, etc.) The value is based on investing in primary care patient centered medical homes resulting in improved quality of care and patient experiences and costs compared to non-PCMH patients and reductions in expensive hospital and emergency department utilization. This totaled approximately $4,225,000 for 5 years.
The population expected to be positively impacted by the project for reduction in Behavior Health/Substance Abuse admission rate and Behavior Health/Substance Abuse Readmission rate by DY 5. The estimated cost for a Behavior Health/Substance abuse admission from internal data is $1878. A reduction of 230 admissions was valued at $431,940. A reduction of 161 readmissions was valued at $302,358. This totaled approximately $734,298.

The remainder of $53,125 for total value was reduced to balance total funding.
The total value of the project then was estimated at $4,906,173. Approximately 80.63% of the total value was assigned to Category 2 project ($3,901,150). The remaining 10.24% of value was assigned to Category 3 outcome for Behavior Health/Substance Abuse Admission Rate ($502,512) and 10.24% of value was assigned to Cat 3 outcome for Behavior/Substance Abuse Re-Admission-30day ($502,511).

020943901.3.6	*3.IT-2.4*	*Behavioral Health/Substance Abuse (BH/SA) Admission Rate*	
Medical City Dallas			*020943901*
Related Category 1 or 2 Projects:	*020943901.2.1*		
Starting Point/Baseline:	*Identify all patients with Behavioral Health and Substance abuse primary diagnosis and significant secondary diagnosis*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: submission of planGoal: Plan Data Source Integrated Primary and Psychiatric Care Plan Process Milestone 1 Estimated Incentive Payment: $32,050 **Process Milestone 2** [P- 2]: Establish baseline rates Metric 1: Number of patients in need of primary care provider Goal: Baseline Data Source: Integrated Primary and Psychiatric Care Plan Process Milestone 2 Estimated Incentive Payment*:* $32,050	**Process Milestone 3** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: submission of documentation of findings and communication Goal: Stakeholder meetings Data Source: Integrated Primary and Psychiatric Care Plan Process Milestone 3 Estimated Incentive Payment: $70,333	**Outcome Improvement Target 1** [IT-2.4]: Improvement Target: .7% reduction over baseline for behavioral health/substance abuse primary and significant secondary diagnosis, 142 admissions Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $112,859	**Outcome Improvement Target 2** [IT-2.4]: Improvement Target: 1.3%reduction over baseline for behavioral health/substance abuse primary and significant secondary diagnosis, 230 admissions Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $255,220
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $64,100	Year 3 Estimated Outcome Amount: $70,333	Year 4 Estimated Outcome Amount: $112,859	Year 5 Estimated Outcome Amount: $255,220
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $502,512			

Title of Outcome Measure (Improvement Target): IT-3.8 Behavioral Health/Substance Abuse (BH/SA) 30 day readmission Rate

Unique RHP outcome identification number(s): 020943901.3.7

Performing Provider Name/TPI: Medical City Dallas/020943901

Outcome Measure Description

IT-3.8 Behavioral Health/Substance Abuse (BH/SA) 30 day readmission Rate

The outcome measure is to reduce preventable readmissions to hospitals for those patients that with a Behavioral Health or Substance Abuse primary diagnosis or when a significant secondary diagnosis. The target for the outcome measure is to reduce the rate by 20% by the end of the waiver period.

Process Milestone

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. It will also be necessary establish a base line rate for re-admissions in order to correctly measure a rate reduction. In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders.

Outcome improvement Targets for each year

Our goal is to reduce to reduce Behavioral Health/Substance Abuse (BH/SA) 30 day readmission rate by DY3-5%, DY4-5%and DY 5-10% for a total reduction of 20%. We estimate the current number of readmission per year to 807, total reduced readmissions is estimated at 161 by the end of the waiver (DY3-40 DY4-40, DY5-81).

Rationale

In DY 2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders are identified and included in the plan. Identifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan is a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.

It will also be necessary in DY 2 to establish a base line rate for re-admissions in order to correctly measure a the reduction. The process milestone to establish the baseline rate is necessary to understand the starting point of patients to focus on. We have primary diagnosis data analyzed but significant secondary diagnosis will need to be identified and a baseline

established. Also an assessment will be conducted to see patients for which a telemedicine consult would be appropriate.

In DY 3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This would include intervention impacts, learning from follow up on successes or failures and identified best practices. This feedback is significant to adjusting plans findings and continued engagement of stakeholders.

The outcome improvement target will measure the impact and effectiveness of integrating primary and behavioral health care in coordinating care post-discharge.

Outcome Measure Valuation

The economic value of each targeted improvement outcome obtained from evidence based studies was used a guide for the overall value of project. Additional value was considered for resource investments needed, timelines, cost avoidance, community benefit, risks and project scope.
Medical City Dallas defined the population that will be directly impacted by the project as patients receive a primacy care medical home at the integrated primary care and behavioral care clinic.. The population expected to be positively impacted by the project for primary care and medical home is 2,500 patients by DY 5. The estimated pricing for medical home was $650 per year per patient. This value was obtained from averages of various PCMH studies (Intermountain Healthcare, Blue Cross Blue Shield, etc.) The value is based on investing in primary care patient centered medical homes resulting in improved quality of care and patient experiences and costs compared to non-PCMH patients and reductions in expensive hospital and emergency department utilization. This totaled approximately $4,225,000 for 5 years.
The population expected to be positively impacted by the project for reduction in Behavior Health/Substance Abuse admission rate and Behavior Health/Substance Abuse Readmission rate by DY 5. The estimated cost for a Behavior Health/Substance abuse admission from internal data is $1878. A reduction of 230 admissions was valued at $431,940. A reduction of 161 readmissions was valued at $302,358. This totaled approximately $734,298.

The remainder of $53,125 for total value was reduced to balance total funding.
The total value of the project then was estimated at $4,906,173. Approximately 80.63% of the total value was assigned to Category 2 project ($3,901,150). The remaining 10.24% of value was assigned to Category 3 outcome for Behavior Health/Substance Abuse Admission Rate ($502,512) and 10.24% of value was assigned to Cat 3 outcome for Behavior/Substance Abuse Re-Admission-30day ($502,511).

020943901.3.7	*3.IT-3.8*	*Behavioral Health/Substance Abuse (BH/SA) 30 day readmission Rate*	
Medical City Dallas			*020943901*
Related Category 1 or 2 Projects:	*020943901.2.1*		
Starting Point/Baseline:	*Identify all patients with Behavioral Health and Substance abuse primary diagnosis and significant secondary*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: submission plan Goal: Plan Data Source Integrated Primary and Psychiatric Care Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $32,049 **Process Milestone 2** [P- 2]: Establish baseline rates Metric 1: Number of patients at risk for readmission Goal: Baseline Data Source: Integrated Primary and Psychiatric Care Plan Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $32,050	**Milestone 3** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: submission of documentation of findings and communication Goal: Stakeholder meetings Data Source: Integrated Primary and Psychiatric Care Plan Process Milestone 3 Estimated Incentive Payment: $70,333	**Outcome Improvement Target 1 [IT-2.4]:** Improvement Target: 10% reduction from baseline for BH/SA readmission within 30 days Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $112,859	**Outcome Improvement Target 2** [**IT-2.4]:** Improvement Target: 20% reduction from baseline for BH/SA readmission within 30 days Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $255,220
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $64,099	Year 3 Estimated Outcome Amount: $70,333	Year 4 Estimated Outcome Amount: $112,859	Year 5 Estimated Outcome Amount: $255,220
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $502,511			

Title of Outcome Measure (Improvement Target): IT-4.8 Sepsis mortality

Unique RHP outcome identification number(s): 020950401.3.9

Performing Provider Name/TPI: Medical City Dallas/020943901

Outcome Measure Description

IT-4.8 Sepsis mortality

IT-4.8 Sepsis mortality is the percentage of those patients diagnosed with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction that expire during hospitalization. Mortality rates are very high in US from sepsis. With earlier diagnosis of sepsis and compliance with Sepsis Resuscitation and Management Bundles we will decrease the mortality rate. . We expect to diagnose and treat 1393 sepsis patients (estimated at DY 1- 148, DY2-222 DY3- 278, DY 4- 347, DY 5-400).

Process Milestones

In DY 2 we will establish baseline rates for sepsis mortality to measure for improvement targets. In DY2 and DY3 we will conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. It is expected that the morality rate for this population in DY 2 will initially increase compared to DY 1 due to more patients being correctly diagnosed with new sepsis protocols thus a baseline will be established in DY2 to measure same mortality rates based on same standards of care.

Outcome Improvement Targets for each year

By DY 4 and DY5, the improvement target is Sepsis mortality reduction of 20% by the end of the waiver.

Rationale

The process milestone to establish a baseline rate is necessary to understand the starting point for sepsis mortality as defined by protocol in order to measure improvement in DY 4 and DY 5.

The process milestone selected for conducting Plan Do Study Act (PDSA) will implement a continuous quality improvement model consisting of a logical sequence of four repetitive steps for continuous improvement and learning that will assist in the achievement of improvement targets. By turning ideas into action and connecting action to learning we believe PDSA cycles will facilitate change. The process that can be analyzed and measured with data and compared to predicted results will expedite new changes to be implemented in a disciplined fashion in as necessary repetitive cycle.

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. Each year mortality from severe sepsis and septic shock nationally have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock. The outcome target for mortality was selected as evidence based initiatives put in place can reduce mortality. In order to measure the effectiveness of sepsis initiatives mortality rate reduction will be measured.

Outcome Measure Valuation

Medical City Dallas defined the population that will be directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The population expected to be positively impacted by the project for mortality was 1,393 which was determined based on outcome target for reduction in mortality by 20% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 50. The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $740,000 for 5 years.

The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay of 2 days from baseline average of 10 days per patient. This was estimated at total of reduced in patient days by DY 5 of 888. The estimated cost per day for a sepsis patient is $1,055. This totaled approximately $1,171,050 ($234,040 average per year).

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $740,000.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 3. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $702,630.

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of mortality reduction at $716,847.
To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $585,525.

The total value of the project then was estimated at $4,656,052. Approximately 80.64% of the total value was assigned to Category 2 project ($3,753,964)and the remaining 9.68% of value assigned to Category 3 outcome for Sepsis Mortality ($451,044) and 9.68% assigned to Category 3 outcome for reduced Average Length of Stay ($451,044).

020943901.3.9	*3.IT-4.8*	*Sepsis mortality*	
Medical City Dallas			*20943901*
Related Category 1 or 2 Projects::	*020943901.2.3*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients hospitalized with sepsis, severe sepsis or septic shock and/or an infection & organ dysfunction.* *Target population: patients hospitalized with severe sepsis or septic shock and/or an infection and organ dysfunction.*		
Year 2 (10/1/2012 – 9/30/2013)	**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 Metric 1: Number of patients treated with Sepsis Resuscitation and Management Bundles Goal: Baseline Data Source: EHR Process Milestone 1 Estimated Incentive*:* $26,080 **Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: : Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Initiative Plan Process Milestone 2 Estimated Incentive Payment*:* $26,081	**Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: : Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Initiative Plan Process Milestone 3 Estimated Incentive Payment: $61,388	**Outcome Improvement Target 1** [IT-4.8]: Improvement Target: 15% reduction in mortality Data Source: Outcome Improvement Target 1 Estimated Incentive Payment*:* $98,507	**Outcome Improvement Target 2** [IT-4.8]: Improvement Target: 20% reduction in mortality from base line Data Source Outcome Improvement Target 2 Estimated Incentive Payment*:* $238,988
Year 2 Estimated Outcome Amount: $52,161	Year 3 Estimated Outcome Amount: $61,388	Year 4 Estimated Outcome Amount: $98,507	Year 5 Estimated Outcome Amount: $238,988
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $451,044			

Title of Outcome Measure (Improvement Target): IT-4.9 Average length of stay

Unique RHP outcome identification number(s): 020943901.3.10

Performing Provider Name/TPI: Medical City Dallas/020943901

Outcome Measure Description

IT- 4.9: Average length of stay is the number days a patient is hospitalized when diagnosed with severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl). With earlier diagnosis of sepsis and compliance with Sepsis Resuscitation and Management of care, average length stay should decrease as result. We expect to diagnose and treat 1393 sepsis patients (estimated at DY 1- 148, DY2-222 DY3- 278, DY 4- 347, DY 5-400).

Process Milestones

In DY 2 we will establish baseline rates for sepsis average length of stay to measure for improvement targets. In DY2 and 3 we will conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. It is expected that the average length of stay for this population in DY 2 will initially be different compared to DY 1 due to more patients being correctly diagnosed with new sepsis protocols thus a baseline will be established in DY2 to measure length of stay based on same standards of care.

Outcome Improvement Targets for each year

By DY 4 and DY5, the improvement target is Sepsis average length of stay of 20% by the end of the waiver.

Rationale

The process milestone to establish a baseline rate is necessary to understand the starting point for the average length of stay for patient receiving Sepsis Resuscitation Management Bundle Care in order to measure improvement in DY 4 and DY 5. Typically average length of stay for ICU has been measure but not for the entire hospitalization.

The process milestone selected for conducting Plan Do Study Act (PDSA) will implement a continuous quality improvement model consisting of a logical sequence of four repetitive steps for continuous improvement and learning that will assist in the achievement of improvement targets. By turning ideas into action and connecting action to learning we believe PDSA cycles will facilitate change. The process that can be analyzed and measured with data and compared to predicted results will expedite new changes to be implemented in a disciplined fashion in as necessary repetitive cycle.

The outcome improvement target to reduce length of stay was selected to measure the effectiveness of evidence based care initiatives for sepsis diagnosis and treatment. Average length of stay reduction can also show advancement of sepsis care that is effective through the continuum of the hospital not just in critical care units and comprehensive, coordinated discharge planning.

Outcome Measure Valuation

Medical City Dallas defined the population that will be directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The population expected to be positively impacted by the project for mortality was 1,393 which was determined based on outcome target for reduction in mortality by 20% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 50. The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $740,000 for 5 years.

The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay of 2 days from baseline average of 10 days per patient. This was estimated at total of reduced in patient days by DY 5 of 888. The estimated cost per day for a sepsis patient is $1,055. This totaled approximately $1,171,050 ($234,040 average per year).

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $740,000.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 3. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $702,630.

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of mortality reduction at $716,847.
To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $585,525.

The total value of the project then was estimated at $4,656,052. Approximately 80.64% of the total value was assigned to Category 2 project ($3,753,964) and the remaining 9.68% of value assigned to Category 3 outcome for Sepsis Mortality ($451,044) and 9.68% assigned to Category 3 outcome for reduced Average Length of Stay ($451,044).

020943901.3.10	*3.IT-4.9*	*Average length of stay (Non-standalone measure)*	
	Medical City Dallas		*020943901*
Related Category 1 or 2 Projects:	*020934901.2.3*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients hospitalized with sepsis, severe sepsis or septic shock and/or aninfection and organ dysfunction* *Target population: patients hospitalized with severe sepsis or septic shock and/or aninfection and organ dysfunction.*		
Year 2 (10/1/2012 – 9/30/2013)	**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 Metric 1: ALOS for patients treated with Sepsis Resuscitation and Management Bundles Goal: Baseline Data Source: EHR Process Milestone 1 Estimated Incentive Payment *:*$26,080 **Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Improvement Plan Process Milestone 2 Estimated Incentive Payment*:* $26,081	**Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Improvement Plan Process Milestone 3 Estimated Incentive Payment: $61,388	**Outcome Improvement Target 1** [IT-4.9]: Improvement Target: 10% reduction from baseline for average length of stay Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $98,507	**Outcome Improvement Target 2** [IT-4.9]: Improvement Target: 20% reduction from baseline for average length of stay Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $238,988
Year 2 Estimated Outcome Amount: $52,161	Year 3 Estimated Outcome Amount: $61,388	Year 4 Estimated Outcome Amount: $98,507	Year 5 Estimated Outcome Amount: $238,988
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $451,044			

Title of Outcome Measure (Improvement Target): IT -11.5 All-Cause Admission Rate for Chronically-Ill patients

Unique RHP outcome identification number(s): 020943901.3.11 (Pass 2)
Performing Provider/TPI: Medical City Dallas/020943901

Outcome Measure Description:
The All-Cause Admission Rate for Chronically-Ill patients referred from Medical City Dallas to Metrocrest Family Medical Clinic is intended to measure admission rate for chronically ill medical home patients post enrollment. The rate is arrived at using numerator which is the number of all-cause inpatient admissions in one year by patients in the denominator - and the denominator which is the number of uninsured patients with a chronic disease (diagnosis of Diabetes, CHF, Hypertension, COPD, or Asthma) referred from hospital to Metrocrest Family Medical Clinic who have been enrolled in the medical home program at least one year.

Process Milestones:
By the end of DY2, the All-Cause Admission rate for chronically ill patients' milestone baseline will be established. We estimate that current admission rate is 30%.

Outcome improvement targets:
The admission rate improvement for DY3, DY4 and DY5 will be 5%, 10% and 15% under baseline respectively. At estimated current admission rate of 30%, 450 admission ocur each year. We expect to reduce these admisions by DY3-23, DY4-23 and DY5-24 for a total admission reduction of 70.

Rationale:
As indicated in the Dallas Fort Worth Hospital Council's RHP 9 Community Needs Assessment, an analysis of the emergency department encounters demonstrates that many in the population are accessing emergency departments for both urgent and non-urgent conditions. Emergency room encounters that result in an in-patient admission tend to be more complex in nature and based on the data, the most frequent conditions that lead to admissions were: stroke, congestive heart failure, weak/failing kidneys, heart attack, and chronic bronchitis. There is a correlation between hospitalization for chronically-ill patients and access to primary care. Timely and effective primary care could reduce the risk of hospitalizations due to ambulatory care sensitive conditions. Therefore, the All-Cause Admission rate for MMH patients demonstrates one of the benefits of connecting a patient to a patient centered medical home. As stated by Bindman and others in JAMA (Volume 274:4), "at a community level there is a strong positive association between health care access and preventable hospitalization rates…"

Outcome Measure Valuation:
Medical City Dallas defined the population that will be directly impacted by the project as patients assigned a medical home at the Metrocrest clinic. There were 2 measures used for this project valuation, patient provided a medical home and reduced admissions. The population

expected to be positively impacted by the project for primary care and medical home is 2080 patients by DY 5. Full value was given to new patients estimated assigned to medical home (DY2-180, DY3-228, DY4-274, DY5-329) but only 70% of value was given to patients already clients of clinic (1050). The estimated pricing for medical home was $650 per year per patient. This value was obtained from averages of various PCMH studies (Intermountain Healthcare, Blue Cross Blue Shield, etc.) The value is based on investing in primary care patient centered medical homes resulting in improved quality of care and patient experiences and costs compared to non-PCMH patients and reductions in expensive hospital and emergency department utilization. This totaled approximately $ 3,392,430 for 4 years.
The population expected to be positively impacted by the project for reduction in All –cause admissions 70 admissions by DY 5. The estimated cost for admissions from internal data is $7,100. This totaled approximately $497,000

The remainder of $66,847 for total value was reduced to balance total funding.
The total value of the project then was estimated at $3,822,583. Approximately 78.68% of the total value was assigned to Category 2 project ($3,007,899)and the remaining 21.31%% of value assigned to Category 3 outcome for All Cause Admission ($814,684).

020943901.3.11	*IT-11.5*	*All-Cause Admission Rate for Chronically-Ill patients*	
	Medical City Dallas		*020943901*
Related Category 1 or 2 Projects:	*020943901.2.4*		
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-2]: Establish and document baseline for new medical home patient admissions per patient per year Metric 1: all-cause admission rate for chronically-ill patients referred from Medical City Dallas to Metrocrest Family Medical Clinic Goal: Baseline Data Source: admissions data from hospital database Numerator: number of all-cause inpatient admissions in one year by patients in the denominator Denominator: number of uninsured patients with a chronic disease (diagnosis of Diabetes, CHF, Hypertension, COPD, or Asthma) referred from hospital to Metrocrest Family Medical Clinic who have been enrolled in the medical home program at least one year Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $88,435	**Outcome Improvement Target 1** [IT-11.5]: Improvement Target: Achieve an admission rate approximately 5% lower than baseline for patients enrolled at least one year in medical home.,23 admission from baseline Data Source: admissions data from hospital database Outcome Improvement Target 1 Estimated Incentive Payment*:* $153,762	**Outcome Improvement Target 2** [IT-11.5]: Improvement Target: Achieve an admission rate approximately 10% lower than baseline for patients enrolled at least one year in medical home, 46 admission from baseline Data Source: admissions data from hospital database Outcome Improvement Target 2 Estimated Incentive Payment*:* $172,347	**Outcome Improvement Target 3** [IT-11.5]: Improvement Target: Achieve an admission rate approximately 10% lower than baseline) for patients enrolled at least one year in medical home.70 admisssion s from baseline Data Source: admissions data from hospital database Outcome Improvement Target 3 Estimated Incentive Payment*:* $400,140

020943901.3.11	*IT-11.5*	*All-Cause Admission Rate for Chronically-Ill patients*	
Medical City Dallas			*020943901*
Related Category 1 or 2 Projects:	*020943901.2.4*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $88,435	Year 3 Estimated Outcome Amount: $153,762	Year 4 Estimated Outcome Amount: $ 172,347	Year 5 Estimated Outcome Amount: $400,140
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $814,684			

Title of Outcome Measure (Improvement Target): IT-1.11 Diabetes Care: Blood Pressure Control

Unique RHP outcome identification number(s): 126679303.3.1
Performing Provider Name/TPI: Methodist Charlton Medical Center/126679303

Outcome Measure Description

The outcome measure of Diabetes Care: Blood Pressure Poor Control rate will result in a 3% improvement by DY5 of patients in the program with controlled blood pressure. Out of the 1,439 patients expected to be in the program, 25% or 360 are expected to have controlled blood pressure levels. The project seeks to improve this number by 1.5% in DY4 and an additional 1.5% in DY5 of targeted patients in the program with controlled blood pressure. This project will identify patients in the ED patients that are identified as having poor diabetes control. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market ultimately leading to better diabetes control outcomes. By mid-DY2, project planning will be conducted by engaging multi-disciplinary stakeholders, identifying current capacity and needed resources. Establishment of baseline rates will provide an opportunity to adjust targets on the number of patients that meet the criteria to receive care under the chronic care model. During DY 3, an effort to disseminate findings and summary of the chronic disease care model and project plan will result in stakeholders having a better knowledge base of the program.

IT-1.11 – Diabetes Care: Blood Pressure Control (Stand-alone Measure)

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: Please refer to table

Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the US. Approximately 20.8 million Americans have diabetes and half of 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.

Outcome Measure Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

126679303.3.1	*3.IT-1.11*	*Diabetes Care: Blood Pressure Control*	
Methodist Charlton Medical Center			*126679303*
Related Category 1 or 2 Projects:	*126679303.2.1 Expand Chronic Care Management Models*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $22,277 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Administrative records Process Milestone 2 Estimated Incentive Payment (max amount): $22,278	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $51,645	**Outcome Improvement Target 1** - [IT1.11]: Diabetes care: Blood pressure control (<140/80mm Hg) Improvement Target: decrease diabetic ED patients targeted in the chronic care program with controlled blood pressure by 1.5% or 5 patients. Baseline: 360 patients / Goal: increase of 1.5% or 5 patients. Data Source: Administrative records Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $82,871	**Improvement Target 2** [IT1.11]: Diabetes care: Blood pressure control (<140/80mm Hg) Improvement Target: decrease diabetic ED patients targeted in the chronic care program with controlled blood pressure by 1.5% over DY4 or 5 patients. Baseline: 365 / Goal: increase of 1.5% over DY4 or 5 patients. Data Source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $198,169
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $44,555	Year 3 Estimated Outcome Amount: $51,645	Year 4 Estimated Outcome Amount: $82,871	Year 5 Estimated Outcome Amount: $198,169
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $377,240			

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes Care: HbA1c Poor Control

Unique RHP outcome identification number(s): 126679303.3.2

Performing Provider Name/TPI: Methodist Charlton Medical Center/126679303

Outcome Measure Description

The outcome measure of Diabetes Care: HbA1c Poor Control rate will result in a 3% decrease by DY5 of patients in the program with uncontrolled A1c levels. Out of the 1,439 patients expected to be in the program, 65% or 935 are expected to have uncontrolled A1c levels. The project seeks to decrease this number by 1.5% in DY4 and an additional 1.5% in DY5 of targeted patients in the program with uncontrolled A1c levels. This project will identify patients in the ED patients that are identified as having poor diabetes control. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market ultimately leading to better diabetes control outcomes. By mid-DY2, project planning will be conducted by engaging multi-disciplinary stakeholders, identifying current capacity and needed resources. Establishment of baseline rates will provide an opportunity to adjust targets on the number of patients that meet the criteria to receive care under the chronic care model. During DY 3, an effort to disseminate findings and summary of the chronic disease care model and project plan will result in stakeholders having a better knowledge base of the program.

IT-1.10 – Diabetes Care: HbA1C Poor Control (Stand-alone Measure)

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table
    - o

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: Please refer to table

o

Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the US. Approximately 20.8 million Americans have diabetes and half of 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.

Outcome Measure Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

126679303.3.2	*3. IT-1.10*	*Diabetes Care: HbA1c poor control (>9.0%)*	
Methodist Charlton Medical Center			*126679303*
Related Category 1 or 2 Projects:	*126679303.2.1 Expand Chronic Care Management Models*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $22,277 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Administrative records Process Milestone 2 Estimated Incentive Payment (max amount): $22,278	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $51,645	**Improvement Target 1** [IT1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: Decrease diabetic ED patients targeted in the chronic care program with uncontrolled A1c levels from baseline by 1.5% or 14 patients. Baseline: 935 / Goal: decrease of 1.5% or 14 patients. Data Source: Administrative records Estimated Incentive Payment *(maximum amount):* $82,870	**Improvement Target 2** [IT1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: Decrease diabetic ED patients targeted in the chronic care program with uncontrolled A1c levels by 1.5% over DY4 or 14 patients. Baseline: 921 / Goal: decrease of 1.5% or 14 patients. Data Source: Administrative records Estimated Incentive Payment (maximum amount): $198,170
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $44,555	Year 3 Estimated Outcome Amount: $51,645	Year 4 Estimated Outcome Amount: $82,870	Year 5 Estimated Outcome Amount: $198,170
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $377,240			

Title of Outcome Measure (Improvement Target): IT-3.3 Diabetes 30-Day Readmission Rate

Unique RHP outcome identification number(s): 126679303.3.3

Performing Provider Name/TPI: Methodist Charlton Medical Center/126679303

Outcome Measure Description

The outcome measure of diabetic 30-day readmission rate will result in a 10% reduction of the diabetes 30-day readmission rate from the targeted population in DY4 and an additional 10% reduction in DY5 by providing better care sites for frequent users of ED services. The target population in DY4 for the chronic care program is expected to be 1,439 patients. Historically the diabetes readmission rate at the hospital is 5.21%. Therefore, we expect the diabetes 30-day readmission rate among this target population to be 5.21% or 75 patients. In DY4, the goal is to decrease diabetes 30-day readmission to the hospital from this target population by 10% with an additional 10% reduction over DY4 in DY5. By mid-DY2, project planning will be conducted by engaging multi-disciplinary stakeholders, identifying current capacity and needed resources. Establishment of baseline rates will provide an opportunity to adjust targets on the number of patients that meet the criteria to receive care under the chronic care model. During DY 3, an effort to disseminate findings and summary of the chronic disease care model and project plan will result in stakeholders having a better knowledge base of the program.

IT-3.3 – Diabetes 30 Day Readmission Rate

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table
    - o

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: Please refer to table

Rationale

This measure estimates the hospital-level, risk-standardized rate of unplanned, diabetes related readmissions within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The

measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts: surgery, general medicine, cardio-respiratory, cardiovascular and neurology. This measure will indicate the effectiveness of education patients on self-management, providing standing orders, education on chronic disease management and methods for the patient to follow up on the management of their chronic diabetes condition.

Outcome Measure Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

126679303.3.3	*3.IT-3.3*	*Diabetes 30-Day Readmission Rate*	
Methodist Charlton Medical Center			*126679303*
Related Category 1 or 2 Projects:	*126679303.2.1 Expand Chronic Care Management Models*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $22,277 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Administrative records Process Milestone 2 Estimated Incentive Payment (max amount): $22,277	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $51,645	**Improvement Target 1** [IT3.3]: Diabetes 30 day readmission rate Improvement Target: decrease diabetic 30-day readmissions to the hospital from the targeted population by 10% Baseline: 5.21% of the 1,439 eligible program participants (75) / Goal: reduce by 10% or 8 patients. Data Source: Administrative records Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $82,871	**Improvement Target 2** [IT3.3]: Diabetes 30 day readmission rate Improvement Target: decrease diabetes 30-day readmissions to the hospital from the targeted population over prior year by 10% Baseline: 67 / Goal: Reduce by additional 10% or 7 patients. Data Source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $198,170
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $44,554	Year 3 Estimated Outcome Amount: $51,645	Year 4 Estimated Outcome Amount: $82,871	Year 5 Estimated Outcome Amount: $198,170
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $377,240			

Title of Outcome Measure (Improvement Target): IT-9.2: ED Appropriate Utilization

Unique RHP outcome identification number(s): 126679303.3.4

Performing Provider Name/TPI: Methodist Charlton Medical Center/126679303

Outcome Measure Description

The outcome measure of ED appropriate utilization will result in a 5% decrease in ED utilization of frequent ED users targeted by the program by DY5. By mid-DY2, a project plan will be conducted to identify the patient populations to be targeted with the Patient Navigation program, determine our current capacities, identify needed resource, determine timelines and document implementation plans. Developing and testing data will be completed in DY2 by beginning to provide navigation services. In DY3, we will conduct a Plan Do Study Act (PDSA) improvement cycle based on the initial process results of providing the navigation service. In DY3 we will establish a baseline of how many patients who are most at risk of receiving disconnected and fragmented care can be impacted which is expected to be 3,105. In DY4 and DY5 we will achieve a reduction in ED utilization by frequent ED users targeted by the program by 2.5% in DY4 from DY3 and an additional 2.5% in DY5 from and DY4.

IT-9.2 – ED Appropriate Utilization (Stand-alone Measure)

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table
    - o

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: Please refer to table
    - o

Rationale

Our process milestones measure the project planning, plan testing, cycles of improvement and baseline impact rate for which we can reduce in the number of patients that frequently use the ED or are readmitted due to a lack of care in the appropriate location. As a result of these efforts, there will be a reduction in the number of ED visits by frequent ED users targeted in the

program by 5% by DY5. These milestones will measure whether we have increased the number of frequent ED users that are provided navigation services, increased the number of patient navigation resources, and as a result, decreased inappropriate ED utilization.

Outcome Measure Valuation

The process milestones during DY2 and DY3 represent the planning and development of the patient navigation program. Each process milestone is required in order to provide the navigation program. The Improvement Targets in DY4 and DY5 represent the effectiveness of the navigation program. The weighting and valuation methodology considers a slightly higher weight and value to the Improvement Targets in DY4 and DY5, which represents the effectiveness of the program and impact to the frequent users of the ED.

The process milestones during DY2 and DY3 will impact over 30,000 of the ED patients as they are screened and analyzed for potential frequent use and possible patient navigation intervention. The DY4 and DY5 improvement targets each represent a significant improvement to the community and lower costs for frequent users of the ED.

126679303.3.4	*3.IT-9.2*	*ED Appropriate Utilization*	
Performing Provider: Methodist Charlton Medical Center			*TPI:* 126679303
Related Category 1 or 2 Projects:	*126679303.2.2 Establish/Expand Patient Care Navigation Program*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $62,058 **Process Milestone 2** [P-3]: Develop and test data systems Data source: Administrative records Process Milestone 2 Estimated Incentive Payment (max amount): $62,057	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $71,933 **Process Milestone 4** [P-2]: Establish baseline rates, expected to be 3,105. Data source: Administrative records Process Milestone 4 Estimated Incentive Payment (max amount): $71,932	**Outcome Improvement Target 1 –** [IT-9.2]: ED Appropriate utilization Improvement Target: decrease utilization of ED visits from targeted population by 2.5% Data source: Administrative records Estimated Incentive Payment (max amount): $230,855	**Outcome Improvement Target 2** [IT9.2]: ED Appropriate utilization Improvement Target: decrease utilization of ED visits by target population from prior year DY4 by 2.5% Data Source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment (max amount):$552,044
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $124,115	Year 3 Estimated Outcome Amount: $143,865	Year 4 Estimated Outcome Amount: $230,855	Year 5 Estimated Outcome Amount: $552,044
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $1,050,879			

Title of Outcome Measure (Improvement Target): IT-3.1 All Cause Readmission Rate

Unique RHP outcome identification number(s): 126679303.3.5

Performing Provider Name/TPI: Methodist Charlton Medical Center/126679303

Outcome Measure Description

The outcome measure of All cause readmission rate will result in a 5% decrease in all cause readmissions from the target population by DY5 by providing better care sites for frequent users of ED services. By mid-DY2, a needs assessment to identify the patient populations to be targeted with the Patient Navigation program will be conducted. Establishment of 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 navigation education will be completed by the end of DY2. We will begin to provide care management/navigation services to targeted patients by the end of DY2 by providing one new navigator providing service to the first qualified patient. By the end of DY3 we will provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. Reduction in all cause readmissions will be achieved with 2.5% reduction in DY4 from DY3 baseline of 554 readmissions and an additional 2.5% in DY5 from DY4.

IT-3.1 – All Cause Readmission Rate (Stand-alone Measure)

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table
    - o

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: Please refer to table
    - o

Rationale

Our milestones measure the reduction in the number of patients that frequently use the ED; 1) we are increasing the number of patients identified as frequent users of the ED, 2) increasing the number of patient navigators available to provide services to those patients, and 3) increasing the number of patients referred to more appropriate care settings. As a result of these efforts, there will be a reduction in the number of readmissions from the target population by 5% by DY5. These milestones will measure whether we have increased the number of frequent ED users that are provided navigation services, increased the number of patient navigation resources, and as a result, decreased inappropriate ED utilization.

Outcome Measure Valuation

The process milestones during DY2 and DY3 represent the planning and development of the patient navigation program. Each process milestone is required in order to provide the navigation program. The Improvement Targets in DY4 and DY5 represent the effectiveness of the navigation program. The weighting and valuation methodology considers a slightly higher weight and value to the Improvement Targets in DY4 and DY5, which represents the effectiveness of the program and impact to the frequent users of the ED.

The process milestones during DY2 and DY3 will impact over 30,000 of the ED patients as they are screened and analyzed for potential frequent use and possible patient navigation intervention. The DY4 and DY5 improvement targets each represent a significant improvement to the community and lower costs for frequent users of the ED.

126679303.3.5	*3.IT-3.1*	*All Cause 30 Day Readmission Rate*	
Performing Provider: Methodist Charlton Medical Center			*TPI:* 126679303
Related Category 1 or 2 Projects:	*126679303.2.2 Establish/Expand Patient Care Navigation Program*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $62,058 **Process Milestone 2** [P-3]: Develop and test data systems Data source: Administrative records Process Milestone 2 Estimated Incentive Payment (max amount): $62,057	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $71,933 **Process Milestone 4** [P-2]: Establish baseline rates, expected to be 554 readmissions from the target population. Data Source: Administrative records Process Milestone 4 Estimated Incentive Payment (max amount): $71,932	**Outcome Improvement Target 1** [IT3.1]: All cause 30 day readmission rate Improvement Target: decrease readmissions to the hospital from target population by 2.5% Data Source: Administrative records Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $230,855	**Outcome Improvement Target 2** [IT3.1]: All cause 30 day readmission rate Improvement Target: decrease readmissions to the hospital from target population by 2.5% from prior year DY4 Data Source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $552,044
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $124,115	Year 3 Estimated Outcome Amount: $143,865	Year 4 Estimated Outcome Amount: $230,855	Year 5 Estimated Outcome Amount: $552,044
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $1,050,879			

Title of Outcome Measure (Improvement Target): IT-3.1 All Cause Readmission Rate

Unique RHP outcome identification number(s): 135032405.3.1

Performing Provider Name/TPI: Methodist Dallas Medical Center/135032405

Outcome Measure Description

The outcome measure of All Cause Readmission Rate will result in a 5% decrease in all cause readmissions from the target population by DY5 by providing better care sites for frequent users of ED services. By mid-DY2, a needs assessment to identify the patient populations to be targeted with the Patient Navigation program will be conducted. Establishment of 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 navigation education will be completed by the end of DY2. We will begin to provide care management/navigation services to targeted patients by the end of DY2 by providing one new navigator providing service to the first qualified patient. By the end of DY3 we will provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. Reduction in all cause readmissions will be achieved with 2.5% reduction in DY4 from DY3 baseline of 465 readmissions and an additional 2.5% by DY5 from DY4.

IT-3.1 – All Cause Readmission Rate

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
- DY3: Please refer to table

Outcome Improvement Targets for each year

- DY4: Please refer to table
- DY5: Please refer to table

Rationale

Our milestones measure the reduction in the number of patients that frequently use the ED; 1) we are increasing the number of patients identified as frequent users of the ED, 2) increasing the number of patient navigators available to provide services to those patients, and 3) increasing the number of patients referred to more appropriate care settings. As a result of

these efforts, there will be a reduction in the number of readmissions from the target population by 5% by DY5. These milestones will measure whether we have increased the number of frequent ED users that are provided navigation services, increased the number of patient navigation resources, and as a result, decreased inappropriate ED utilization.

Outcome Measure Valuation

The process milestones during DY2 and DY3 represent the planning and development of the patient navigation program. Each process milestone is required in order to provide the navigation program. The Improvement Targets in DY4 and DY5 represent the effectiveness of the navigation program. The weighting and valuation methodology considers a slightly higher weight and value to the Improvement Targets in DY4 and DY5, which represents the effectiveness of the program and impact to the frequent users of the ED.

The process milestones during DY2 and DY3 will impact over 30,000 of the ED patients as they are screened and analyzed for potential frequent use and possible patient navigation intervention. The DY4 and DY5 improvement targets each represent a significant improvement to the community and lower costs for frequent users of the ED.

135030405.3.1	*IT-3.1*	*All Cause 30 Day Readmission Rate*	
Methodist Dallas Medical Center			*135032405*
Related Category 1 or 2 Projects:	*135032405.2.1 - Establish/Expand Patient Care Navigation Program*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $103,461 **Process Milestone 2** [P-3]: Develop and test data systems Data source: Administrative records Process Milestone 2 Estimated Incentive Payment (max amount): $103,461	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $119,924 **Process Milestone 4** [P-2]: Establish baseline rates, expected to be 465 readmissions from the target population. Data source: Administrative records Process Milestone 4 Estimated Incentive Payment (max amount): $119,925	**Outcome Improvement Target 1** [IT3.1]: All cause 30 day readmission rate Improvement Target: decrease readmissions to the hospital from target population by 2.5% Data source: Administrative records Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $384,874	**Outcome Improvement Target 2** [IT3.1]: All cause 30 day readmission rate Improvement Target: decrease readmissions to the hospital from target population by 2.5% from prior year DY4 Data source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $920,352
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $206,922	Year 3 Estimated Outcome Amount: $239,849	Year 4 Estimated Outcome Amount: $384,874	Year 5 Estimated Outcome Amount: $920,352
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $1,751,997			

Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization

Unique RHP outcome identification number(s): 135032405.3.2

Performing Provider Name/TPI: Methodist Dallas Medical Center/135032405

Outcome Measure Description

The outcome measure of ED appropriate utilization will result in a 5% decrease in ED utilization of frequent ED users by DY5. By mid-DY2, a project plan will be conducted to identify the patient populations to be targeted with the Patient Navigation program, determine our current capacities, identify needed resource, determine timelines and document implementation plans. Developing and testing data will be completed in DY2 by beginning to provide navigation services. In DY3, we will conduct a Plan Do Study Act (PDSA) improvement cycle based on the initial process results of providing the navigation service. In DY3 we will establish a baseline of how many patients who are most at risk of receiving disconnected and fragmented care can be impacted which is expected to be 2,600. In DY4 and DY5 we will achieve a reduction in ED utilization by frequent ED users by 2.5% in DY4 from DY3 and an additional 2.5% by DY5 from DY4.

IT-9.2 – ED Appropriate Utilization

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table
    - o

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: Please refer to table
    - o

Rationale

Our process milestones measure the project planning, plan testing, cycles of improvement and baseline impact rate for which we can reduce in the number of patients that frequently use the ED or are readmitted due to a lack of care in the appropriate location. As a result of these efforts, there will be a reduction in the number of ED visits by frequent ED users of 5% by DY5.

These milestones will measure whether we have increased the number of frequent ED users that are provided navigation services, increased the number of patient navigation resources, and as a result, decreased inappropriate ED utilization.

Outcome Measure Valuation

The process milestones during DY2 and DY3 represent the planning and development of the patient navigation program. Each process milestone is required in order to provide the navigation program. The Improvement Targets in DY4 and DY5 represent the effectiveness of the navigation program. The weighting and valuation methodology considers a slightly higher weight and value to the Improvement Targets in DY4 and DY5, which represents the effectiveness of the program and impact to the frequent users of the ED.

The process milestones during DY2 and DY3 will impact over 30,000 of the ED patients as they are screened and analyzed for potential frequent use and possible patient navigation intervention. The DY4 and DY5 improvement targets each represent a significant improvement to the community and lower costs for frequent users of the ED.

135032405.3.2	*IT-9.2*	*ED Appropriate Utilization*	
Methodist Dallas Medical Center			*135032405*
Related Category 1 or 2 Projects:	*135032405.2.1 - Establish/Expand Patient Care Navigation Program*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $103,461 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Administrative records Process Milestone 2 Estimated Incentive Payment (max amount): $103,461	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $119,924 **Process Milestone 4** [P-2]: Establish baseline rates, expected to be 2,600 Data Source: Administrative records Process Milestone 4 Estimated Incentive Payment (max amount): $119,925	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate utilization Improvement Target: decrease utilization of ED visits from targeted population by 2.5% Data Source: Administrative records Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $384,874	**Outcome Improvement Target 2** [IT9.2]: ED Appropriate utilization Improvement Target: decrease utilization of ED visits from target population from prior year DY4 by 2.5% Data Source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $920,352
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $206,922	Year 3 Estimated Outcome Amount: $239,849	Year 4 Estimated Outcome Amount: $384,874	Year 5 Estimated Outcome Amount: $920,352
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $1,751,997			

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes Care: HbA1c poor control

Unique RHP outcome identification number(s): 135032405.3.3

Performing Provider Name/TPI: Methodist Dallas Medical Center/135032405

Outcome Measure Description

The outcome measure of Diabetes Care: HbA1c Poor Control rate will result in a 3% decrease by DY5 of patients in the program with uncontrolled A1c levels. Out of the 1,608 patients expected to be in the program, 65% or 1,045 are expected to have uncontrolled A1c levels. The project seeks to decrease this number by 1.5% in DY4 and an additional 1.5% by DY5 of targeted patients in the program with uncontrolled A1c levels. This project will identify patients in the ED patients that are identified as having poor diabetes control. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market ultimately leading to better diabetes control outcomes. By mid-DY2, project planning will be conducted by engaging multi-disciplinary stakeholders, identifying current capacity and needed resources. Establishment of baseline rates will provide an opportunity to adjust targets on the number of patients that meet the criteria to receive care under the chronic care model. During DY 3, an effort to disseminate findings and summary of the chronic disease care model and project plan will result in stakeholders having a better knowledge base of the program.

IT-1.10 – Diabetes Care: HbA1C Poor Control

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table
    - o

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: Please refer to table
    - o

Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the US. Approximately 20.8 million Americans have diabetes and half of 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.

Outcome Measure Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

135032405.3.3	*IT-1.10*	*Diabetes Care: HbA1c Poor Control (>9.0%)*	
Methodist Dallas Medical Center			*135032405*
Related Category 1 or 2 Projects:	*135032405.2.2 Expand Chronic Care Management Models*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $35,109 **Process Milestone 2 [** P-2]: Establish baseline rates Data Source: Administrative records Process Milestone 2 Estimated Incentive Payment (max amount): $35,110	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Adminstrative records Process Milestone 3 Estimated Incentive Payment (max amount): $81,393	**Improvement Target 1** [IT.1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: Decrease diabetic ED patients targeted in the chronic care program with uncontrolled A1c levels from baseline by 1.5% or 16 patients. Baseline: 1045 / Goal: decrease of 1.5% or 16 patients. Data Source: Administrative records Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $130,608	**Improvement Target 2** [IT.1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: Decrease diabetic ED patients targeted in the chronic care program with uncontrolled A1c levels by 1.5% over DY4 or 15 patients. Baseline: 1029 / Goal: decrease of 1.5% over prior year or 15 patients. Data Source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $312,323
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $70,219	Year 3 Estimated Outcome Amount: $81,393	Year 4 Estimated Outcome Amount: $130,608	Year 5 Estimated Outcome Amount: $312,323
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $594,543			

Title of Outcome Measure (Improvement Target): IT-1.11 Diabetes Care: Blood Pressure Control

Unique RHP outcome identification number(s): 135032405.3.4

Performing Provider Name/TPI: Methodist Dallas Medical Center/135032405

Outcome Measure Description

The outcome measure of Diabetes Care: Blood Pressure Control rate will result in a 3% improvement by DY5 of patients in the program with controlled blood pressure. Out of the 1,608 patients expected to be in the program, 25% or 402 are expected to have controlled blood pressure levels. The project seeks to improve this number by 1.5% in DY4 and an additional 1.5% by DY5 of targeted patients in the program with controlled blood pressure. This project will identify patients in the ED that are identified as having poor diabetes control. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market ultimately leading to better diabetes control outcomes. By mid-DY2, project planning will be conducted by engaging multi-disciplinary stakeholders, identifying current capacity and needed resources. Establishment of baseline rates will provide an opportunity to adjust targets on the number of patients that meet the criteria to receive care under the chronic care model. During DY 3, an effort to disseminate findings and summary of the chronic disease care model and project plan will result in stakeholders having a better knowledge base of the program.

IT-1.11 – Diabetes Care Blood Pressure Control

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table
    - o

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: Please refer to table

Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the US. Approximately 20.8 million Americans have diabetes and half of 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.

Outcome Measure Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

135032405.3.4	*IT-1.11*	*Diabetes Care: Blood Pressure Control*	
Methodist Dallas Medical Center			135032405
Related Category 1 or 2 Projects:	*135032405.2.2 Expand Chronic Care Management Models*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $35,109 **Process Milestone 2 [** P-2]: Establish baseline rates Data Source: Administrative records Process Milestone 2 Estimated Incentive Payment (max amount): $35,110	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $81,393	**Improvement Target 1** [IT.1.11]: Diabetes care: Blood pressure control (<140/80mm Hg) Improvement Target: increase diabetic ED patients targeted in the chronic care program with controlled blood pressure by 1.5% or 6 patients. Baseline: 402 / increase of 1.5% or 6 patients. Data Source: Administrative records Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $130,608	**Improvement Target 2** [IT.1.11]: Diabetes care: Blood pressure control (<140/80mm Hg) Improvement Target: increase diabetic ED patients targeted in the chronic care program with controlled blood pressure by 1.5% over DY4 or 6 patient. Baseline: 408 / increase of 1.5% or 6 patients. Data Source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $312,323
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $70,219	Year 3 Estimated Outcome Amount: $81,393	Year 4 Estimated Outcome Amount: $130,608	Year 5 Estimated Outcome Amount: $312,323
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $594,543			

Title of Outcome Measure (Improvement Target): IT-3.3 Diabetes 30 Day Readmission Rate

Unique RHP outcome identification number(s): 135032405.3.5

Performing Provider Name/TPI: Methodist Dallas Medical Center/135032405

Outcome Measure Description

The outcome measure of diabetic 30-day readmission rate will result in a 10% reduction of the diabetes 30-day readmission rate from the targeted population in DY4 and an additional 10% reduction by DY5 by providing better care sites for frequent users of ED services. The target population in DY4 for the chronic care program is expected to be 1,608 patients. Historically the diabetes readmission rate at the hospital is 8.95% or 142 patients. By mid-DY2, project planning will be conducted by engaging multi-disciplinary stakeholders, identifying current capacity and needed resources. Establishment of baseline rates will provide an opportunity to adjust targets on the number of patients that meet the criteria to receive care under the chronic care model. During DY 3, an effort to disseminate findings and summary of the chronic disease care model and project plan will result in stakeholders having a better knowledge base of the program.

IT-3.3 – Diabetes 30 Day Readmission Rate

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table
    - o

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: Please refer to table
    - o

Rationale

This measure estimates the hospital-level, risk-standardized rate of unplanned, diabetes related readmissions within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts: surgery, general medicine,

cardio-respiratory, cardiovascular and neurology. This measure will indicate the effectiveness of education patients on self-management, providing standing orders, education on chronic disease management and methods for the patient to follow up on the management of their chronic diabetes condition.

Outcome Measure Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

135032405.3.5	*IT-3.3*	*Diabetes 30 Day Readmission Rate*	
Methodist Dallas Medical Center			*135032405*
Related Category 1 or 2 Projects:	*135032405.2.2 Expand Chronic Care Management Models*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $35,109 **Process Milestone 2 [** P-2]: Establish baseline rates Data Source: Administrative records Process Milestone 2 Estimated Incentive Payment (max amount): $35,110	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders. Data Source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $81,393	**Improvement Target 1** [IT.3.3]: Diabetes 30 day readmission rate Improvement Target: decrease diabetic 30-day readmissions to the hospital from the targeted population by 10% Baseline: 3.01% of the 1,608 eligible program participants (48) / Goal: reduce by 10% or 5 patients. Data Source: Administrative records Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $130,608	**Improvement Target 2** [IT.3.3]: Diabetes 30 day readmission rate Improvement Target: decrease diabetic readmissions to the hospital from the targeted population over prior year by 10% Baseline: 43 / Goal: Reduce by additional 10% or 4 patients. Data Source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $312,323
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $70,219	Year 3 Estimated Outcome Amount: $81,393	Year 4 Estimated Outcome Amount: $130,608	Year 5 Estimated Outcome Amount: $312,323
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $594,543			

Title of Outcome Measure (Improvement Target): IT- 11.5 - Addressing Health Disparities in Minority Populations – All Cause Admission for the Chronically Ill

Unique RHP outcome identifier: 135032405.3.6

Performing Provider Name/TPI: Methodist Dallas Medical Center/ 135032405

Outcome Measure Description

IT-11.5 All-Cause Admission Rate for Chronically-Ill patients

Numerator: Number of all-cause inpatient admissions in one year by patients in the denominator

Denominator: Number of uninsured patients with a chronic disease (diagnosis of Diabetes, CHF, Hypertension, COPD, or Asthma) referred from hospital to Medical Home project who have been enrolled in the Medical Home program at least one year

The All-Cause Admission Rate for Chronically-Ill patients referred from Methodist Dallas Medical Center to "The Medical Home" project is intended to measure admission rate for chronically ill The Medical Home project patients post enrollment. The rate is arrived at using numerator which is the number of all-cause inpatient admissions in one year by patients in the denominator - and the denominator which is the number of uninsured patients with a chronic disease (diagnosis of Diabetes, CHF, Hypertension, COPD, or Asthma) referred from hospital to MMH who have been enrolled in the MMH program at least one year.

By the end of DY2, the All-Cause Admission rate for chronically ill patients' milestone baseline will be established. The admission rate improvement for DY3, DY4 and DY5 will be 5%, 10% and 15% under baseline respectively.

Rationale

As indicated in the Dallas Fort Worth Hospital Council's RHP 9 Community Needs Assessment, an analysis of the emergency department encounters demonstrates that many in the population are accessing emergency departments for both urgent and non-urgent conditions. Emergency room encounters that result in an in-patient admission tend to be more complex in nature and based on the data, the most frequent conditions that lead to admissions were: stroke, congestive heart failure, weak/failing kidneys, heart attack, and chronic bronchitis. There is a correlation between hospitalization for chronically-ill patients and access to primary care. Timely and effective primary care could reduce the risk of hospitalizations due to ambulatory care sensitive conditions. Therefore, the All-Cause Admission rate for The Medical Home project patients demonstrates one of the benefits of connecting a patient to a patient centered medical home. As stated by Bindman and others in JAMA (Volume 274:4), "at a

community level there is a strong positive association between health care access and preventable hospitalization rates, …"

Outcome Measure Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

135032405.3.6	*IT-11.5*	*All-Cause Admission Rate for Chronically-Ill patients*	
Methodist Dallas Medical Center			*135032405*
Related Category 1 or 2 Projects:	*135032405.2.3*		
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 1 [P-2]: Establish baseline rates Metric [P-2.1]: all-cause admission rate for chronically-ill patients referred from Methodist Dallas Medical Center to the Medical Home. Data Source: Administrative records Numerator: number of all-cause inpatient admissions in one year by patients in the denominator Denominator: number of uninsured patients with a chronic disease (diagnosis of Diabetes, CHF, Hypertension, COPD, or Asthma) referred from hospital to Medical Home project who have been enrolled in the Medical Home program at least one year Target population: 410 / Expected baseline: 18% Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $79,654	**Outcome Improvement Target 1** [IT-11.5]: Improvement Target: Achieve an admission rate approximately 5% lower than baseline of 74 patients for patients enrolled at least one year in the Medical Home project. Data Source: Administrative records Outcome Improvement Target 1 Estimated Incentive Payment*:* $86,537	**Outcome Improvement Target 2** [IT-11.5]: Improvement Target: Achieve an admission rate approximately 10% lower than baseline of 74 patients for patients enrolled at least one year in the Medical Home project. Data Source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment*:* $142,676	**Outcome Improvement Target 3** [IT-11.5]: Improvement Target: Achieve an admission rate approximately 15% lower than baseline of 74 patients for patients enrolled at least one year in the Medical Home project. Data Source: Administrative records Outcome Improvement Target 3 Estimated Incentive Payment*:* $354,704
Year 2 Estimated Outcome Amount: $79,654	Year 3 Estimated Outcome Amount: $86,537	Year 4 Estimated Outcome Amount: $142,676	Year 5 Estimated Outcome Amount: $354,704
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $663,571			

Title of Outcome Measure (Improvement Target): IT-3.1 All Cause Readmission Rate

Unique RHP outcome identification number(s): 209345201.3.1

Performing Provider Name/TPI: Methodist Richardson Medical Center/209345201

Outcome Measure Description

The outcome measure of All cause readmission rate will result in a 3% decrease in all cause readmissions from the target population by DY5 by providing better care sites for frequent users of ED services. By mid-DY2, a needs assessment to identify the patient populations to be targeted with the Patient Navigation program will be conducted. Establishment of 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 navigation education will be completed by the end of DY2. We will begin to provide care management/navigation services to targeted patients by the end of DY2 by providing one new navigator providing service to the first qualified patient. By the end of DY3 we will provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. Reduction in all cause readmissions will be achieved with 2.5% reduction in DY4 from DY3 baseline of 111 readmissions and an additional 2.5% in DY5 from and DY4.

IT-3.1 – All Cause Readmission Rate

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table
    - o

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: Please refer to table
    - o

Rationale

Our milestones measure the reduction in the number of patients that frequently use the ED; 1) we are increasing the number of patients identified as frequent users of the ED, 2) increasing the number of patient navigators available to provide services to those patients, and 3) increasing the number of patients referred to more appropriate care settings. As a result of these efforts, there will be a reduction in the number of readmissions from the target population by 5% by DY5. These milestones will measure whether we have increased the number of frequent ED users that are provided navigation services, increased the number of patient navigation resources, and as a result, decreased inappropriate ED utilization.

Outcome Measure Valuation

The process milestones during DY2 and DY3 represent the planning and development of the patient navigation program. Each process milestone is required in order to provide the navigation program. The Improvement Targets in DY4 and DY5 represent the effectiveness of the navigation program. The weighting and valuation methodology considers a slightly higher weight and value to the Improvement Targets in DY4 and DY5, which represents the effectiveness of the program and impact to the frequent users of the ED.

The process milestones during DY2 and DY3 will impact over 30,000 of the ED patients as they are screened and analyzed for potential frequent use and possible patient navigation intervention. The DY4 and DY5 improvement targets each represent a significant improvement to the community and lower costs for frequent users of the ED.

209345201.3.1	*3.IT-3.1*	*All Cause 30 Day Readmission Rate*	
Performing Provider: Methodist Richardson Medical Center			209345201
Related Category 1 or 2 Projects:	*209345201.2.1 Establish/Expand Patient Navigation Program*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $22,174 **Process Milestone 2** [P-3]: Develop and test data systems Process Milestone 2 Estimated Incentive Payment (max amount): $22,174	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $25,703 **Process Milestone 4** [P-2]: Establish baseline rates, expected to be 111 readmissions from the target population. Process Milestone 4 Estimated Incentive Payment (max amount): $25,703	**Outcome Improvement Target 1** [IT3.1]: All cause 30 day readmission rate Improvement Target: decrease readmissions to the hospital from target population by 2.5% Data Source: Administrative records Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $82,489	**Outcome Improvement Target 2** [IT3.1]: All cause 30 day readmission rate Improvement Target: decrease readmissions to the hospital from target population by 2.5% from prior year DY4 Data Source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $197,256
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $44,348	Year 3 Estimated Outcome Amount: $51,406	Year 4 Estimated Outcome Amount: $82,489	Year 5 Estimated Outcome Amount: $197,256
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $375,499			

Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization

Unique RHP outcome identification number(s): 209345201.3.2

Performing Provider Name/TPI: Methodist Richardson Medical Center/209345201

Outcome Measure Description

The outcome measure of ED appropriate utilization will result in a 5% decrease in ED utilization of frequent ED users. By mid-DY2, a project plan will be conducted to identify the patient populations to be targeted with the Patient Navigation program, determine our current capacities, identify needed resource, determine timelines and document implementation plans. Developing and testing data will be completed in DY2 by beginning to provide navigation services. In DY3, we will conduct a Plan Do Study Act (PDSA) improvement cycle based on the initial process results of providing the navigation service. In DY3 we will establish a baseline of how many patients who are most at risk of receiving disconnected and fragmented care can be impacted which is expected to be 1,445. In DY4 and DY5 we will achieve a reduction in ED utilization by frequent ED users by 2.5% in DY4 from DY3 and an additional 2.5% in DY5 from DY4.

IT-9.2 – ED Appropriate Utilization (Stand-alone Measure)

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table
    - o

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: : Please refer to table
    - o

Rationale

Our process milestones measure the project planning, plan testing, cycles of improvement and baseline impact rate for which we can reduce in the number of patients that frequently use the ED or are readmitted due to a lack of care in the appropriate location. As a result of these

efforts, there will be a reduction in the number of ED visits by frequent ED users of 5% by DY5. These milestones will measure whether we have increased the number of frequent ED users that are provided navigation services, increased the number of patient navigation resources, and as a result, decreased inappropriate ED utilization.

Outcome Measure Valuation

The process milestones during DY2 and DY3 represent the planning and development of the patient navigation program. Each process milestone is required in order to provide the navigation program. The Improvement Targets in DY4 and DY5 represent the effectiveness of the navigation program. The weighting and valuation methodology considers a slightly higher weight and value to the Improvement Targets in DY4 and DY5, which represents the effectiveness of the program and impact to the frequent users of the ED.

The process milestones during DY2 and DY3 will impact over 30,000 of the ED patients as they are screened and analyzed for potential frequent use and possible patient navigation intervention. The DY4 and DY5 improvement targets each represent a significant improvement to the community and lower costs for frequent users of the ED.

209345201.3.2	*3.IT-9.2*	*ED Appropriate Utilization*	
Methodist Richardson Medical Center			209345201
Related Category 1 or 2 Projects:	*209345201.2.1 Establish/Expand a Patient Care Navigation Program*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $22,174 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Administrative records Process Milestone 2 Estimated Incentive Payment (max amount): $22,174	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $25,703 **Process Milestone 4** [P-2]: Establish baseline rates, expected to be 1,445 Data Source: Administrative records Process Milestone 4 Estimated Incentive Payment (max amount): $25,703	**Outcome Improvement Target 1 -** [IT-9.2]: ED Appropriate utilization Improvement Target: decrease utilization of ED visits from targeted population by 2.5% Data Source: Administrative records Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $82,489	**Outcome Improvement Target 2** [IT9.2]: ED Appropriate utilization Improvement Target: decrease utilization of ED visits by target population from prior year DY4 by 2.5% Data Source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $197,256
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $44,348	Year 3 Estimated Outcome Amount: $51,406	Year 4 Estimated Outcome Amount: $82,489	Year 5 Estimated Outcome Amount: $197,256
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $375,499			

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes Care: HbA1C Poor Control

Unique RHP outcome identification number(s): 209345201.3.3

Performing Provider Name/TPI: Methodist Richardson Medical Center/209345201

Outcome Measure Description

The outcome measure of Diabetes Care: HbA1c Poor Control rate will result in a 3% decrease by DY5 of patients in the program with uncontrolled A1c levels. Out of the 180 patients expected to be in the program, 65% or 117 are expected to have uncontrolled A1c levels. The project seeks to decrease this number by 1.5% in DY4 and an additional 1.5% in DY5 of targeted patients in the program with uncontrolled A1c levels. This project will identify patients in the ED patients that are identified as having poor diabetes control. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market ultimately leading to better diabetes control outcomes. By mid-DY2, project planning will be conducted by engaging multi-disciplinary stakeholders, identifying current capacity and needed resources. Establishment of baseline rates will provide an opportunity to adjust targets on the number of patients that meet the criteria to receive care under the chronic care model. During DY 3, an effort to disseminate findings and summary of the chronic disease care model and project plan will result in stakeholders having a better knowledge base of the program.

IT-1.10 – Diabetes Care: HbA1C Poor Control

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table
    - o

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: Please refer to table
    - o

Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the US. Approximately 20.8 million Americans have diabetes and half of 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.

Outcome Measure Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

209345201.3.3	*3.IT-1.10*	*Diabetes care: HbA1c poor control (>9.0%)*	
Methodist Richardson Medical Center			*TPI:* 209345201
Related Category 1 or 2 Projects:	*209345201.2.2 Expand Chronic Care Management Models*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $9,855 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Administrative records Process Milestone 2 Estimated Incentive Payment (max amount): $9,855	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $22,847	**Improvement Target 1** [IT1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: decrease diabetic ED patients targeted in the chronic care program with uncontrolled A1c levels from baseline by 1.5% or 2 patients. Baseline: 117/Goal: decrease of 1.5% or 2 patients Data Source: Administrative records Estimated Incentive Payment (maximum amount): $36,661	**Improvement Target 2** [IT1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: decrease diabetic ED patients targeted in the chronic care program with uncontrolled A1c levels by 1.5% over DY4 or 2 patients. Baseline: 115 / Goal: decrease of 1.5% or 2 patients. Data Source: Administrative records Estimated Incentive Payment (maximum amount): $87,669
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $19,710	Year 3 Estimated Outcome Amount: $22,847	Year 4 Estimated Outcome Amount: $36,661	Year 5 Estimated Outcome Amount: $87,669
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $166,887			

Title of Outcome Measure (Improvement Target): IT-1.11 Diabetes Care: Blood Pressure Control

Unique RHP outcome identification number(s): 209345201.3.4

Performing Provider Name/TPI: Methodist Richardson Medical Center/209345201

Outcome Measure Description

The outcome measure of Diabetes Care: Blood Pressure Control rate will result in a 3% improvement by DY5 of patients in the program with controlled blood pressure. Out of the 1000 patients expected to be in the program, 25% or 45 are expected to have controlled blood pressure levels. The project seeks to improve this number by 1.5% in DY4 and an additional 1.5% in DY5 of targeted pratients in the program with controlled blood pressure. This project will identify patients in the ED that are identified as having poor diabetes control. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market ultimately leading to better diabetes control outcomes. By mid-DY2, project planning will be conducted by engaging multi-disciplinary stakeholders, identifying current capacity and needed resources. Establishment of baseline rates will provide an opportunity to adjust targets on the number of patients that meet the criteria to receive care under the chronic care model. During DY 3, an effort to disseminate findings and summary of the chronic disease care model and project plan will result in stakeholders having a better knowledge base of the program.

IT-1.11 – Diabetes Care: Blood Pressure Control

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table
    - o

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: Please refer to table
    - o

Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the US. Approximately 20.8 million Americans have diabetes and half of 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.

Outcome Measure Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

209345201.3.4	*3.IT-1.11*	*Diabetes Care: Blood pressure poor control (<140/80mm Hg)*	
Methodist Richardson Medical Center			*TPI:* 209345201
Related Category 1 or 2 Projects:	*209345201.2.2 Expand Chronic Care Management Models*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $9,855 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Provider documents Process Milestone 2 Estimated Incentive Payment (max amount): $9,855	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $22,847	**Outcome Improvement Target 1** [IT1.11]: Diabetes care: Blood pressure control (<140/80mm Hg) Improvement Target: increase diabetic ED patients targeted in the chronic care program with controlled blood pressure by 1.5% or 1 patient. Baseline: 45 patients/Goal: increase of 1.5% or 1 patient. Data Source: Administrative records Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $36,661	**Outcome Improvement Target 2** [IT1.11]: Diabetes care: Blood pressure control (<140/80mm Hg) Improvement Target: increase diabetic ED patients targeted in the chronic care program with controlled blood pressure by 1.5% over DY4 or 1 patient. Baseline: 46 patients/Goal: increase of 1.5% or 1 patient. Data Source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $87,669
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $19,710	Year 3 Estimated Outcome Amount: $22,847	Year 4 Estimated Outcome Amount: $36,661	Year 5 Estimated Outcome Amount: $87,669
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $166,887			

Title of Outcome Measure (Improvement Target): IT-3.3 Diabetes 30 Day Readmission Rate

Unique RHP outcome identification number(s): 209345201.3.5

Performing Provider Name/TPI: Methodist Richardson Medical Center/209345201

Outcome Measure Description

The outcome measure of diabetic 30-day readmission rate will result in a 10% reduction of the diabetes 30-day readmission rate from the targeted population in DY4 and an additional 10% reduction in DY5 by providing better care sites for frequent users of ED services. The target population in DY4 for the chronic care program is expected to be 180 patients. Historically the diabetes readmission rate at the hospital is 6.07% or 11 patients. By mid-DY2, project planning will be conducted by engaging multi-disciplinary stakeholders, identifying current capacity and needed resources. Establishment of baseline rates will provide an opportunity to adjust targets on the number of patients that meet the criteria to receive care under the chronic care model. During DY 3, an effort to disseminate findings and summary of the chronic disease care model and project plan will result in stakeholders having a better knowledge base of the program.

IT-3.3 – Diabetes 30 Day Readmission Rate

- Rate 1: N/A
- Rate 2: N/A

Process Milestones

- DY2: Please refer to table
    - o
- DY3: Please refer to table
    - o

Outcome Improvement Targets for each year

- DY4: Please refer to table
    - o
- DY5: Please refer to table

Rationale

This measure estimates the hospital-level, risk-standardized rate of unplanned, diabetes related readmissions within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts: surgery, general medicine, cardio-respiratory, cardiovascular and neurology. This measure will indicate the effectiveness of education patients on self-management, providing standing orders, education on chronic disease management and methods for the patient to follow up on the management of their chronic diabetes condition.

Outcome Measure Valuation

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Healthcare cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Healthcare value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

209345201.3.5	*3.IT-3.3*	*Diabetes 30 day readmission rate*	
Methodist Richardson Medical Center			*TPI: 209345201*
Related Category 1 or 2 Projects:	*209345201.2.2 Expand Chronic Care Management Models*		
Starting Point/Baseline:	*To be developed in DY2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Administrative records Process Milestone 1 Estimated Incentive Payment (max amount): $9,855 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Administrative records Process Milestone 2 Estimated Incentive Payment (max amount): $9,855	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Administrative records Process Milestone 3 Estimated Incentive Payment (max amount): $22,847	**Improvement Target 1** [IT3.3]: Diabetes 30 day readmission rate Improvement Target: decrease Diabetic 30-day readmissions to the hospital from the targeted population by 10%. Baseline: 6.07% of the 180 eligible program participants (11) / Goal: reduce by 10% or 1 patient. Data Source: Administrative records Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $36,661	**Improvement Target 2** [IT3.3]: Diabetes 30 day readmission rate Improvement Target: decrease Diabetes 30-day readmissions to the hospital from the targeted population over prior year by 10% Baseline: 10 / Goal: Reduce by additional 10% or 1 patient. Data Source: Administrative records Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $87,669
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $19,710	Year 3 Estimated Outcome Amount: $22,847	Year 4 Estimated Outcome Amount: $36,661	Year 5 Estimated Outcome Amount: $87,669
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $166,887			

Title of Outcome Measure (Improvement Target): IT-1.2 – Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)

Unique RHP outcome identification number: 127295703.3.1

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-1.2 - Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)

Defined as the percentage of established patients 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Numerator: Established patients from the denominator with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year

Inclusions: Established patients must meet one of the following criteria to be compliant:

- Code for a lab panel test during measurement year
- Code for serum potassium & code for serum creatinine during measurement year
- Code for serum potassium & code for blood urea nitrogen during measurement year

Note: Tests don't need to occur on same service date, only within measurement year

Denominator: Established patients 18 years of age or older as of December 31 of the measurement year on persistent angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) – defined as patients who received at least 180 treatment days of ambulatory medication during measurement year.

Inclusions: Members 18 years of age and older as of December 31 of the measurement year on persistent angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) – defined as members who received at least 180 treatment days of ambulatory medication during the measure year. Note:

- Patients must have been continuously enrolled during the measurement year.
- Allowable gap: No more than one gap in enrollment of up to 45 days during each year of continuous enrollments (commercial, Medicare). To determine continuous enrollment for a

Medicaid beneficiary for whom enrollment is verified monthly, the patient may not have more than a 1-month gap in coverage.

- Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days).
- Refer to Table CDC-L in the original measure documentation to identify ACE inhibitors and ARBs. Patients may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days supply for those medication count toward the total 180 treatment days (ie a patient who received 90 days of ACE inhibitors and 90 days of ARBs meet the denominator definition for this measure).

Exclusions: Exclude patients who had an inpatient (acute or non-acute) claim/encounter during the measurement year.

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 a baseline rate among established patients

Outcome Improvement Targets:

- DY4:
    - IT-1.2: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – ACE inhibitors or angiotensin receptor blockers (ARBs)
        - Improvement Target – CHF: 85%
        - Improvement Target – Diabetes: 85%
- DY5:
    - IT-1.2: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – ACE inhibitors or angiotensin receptor blockers (ARBs)
        - Improvement Target – CHF: 88%

- Improvement Target – Diabetes: 88%

Rationale

Hypertension and diabetes are two of Parkland's most common diagnoses, resulting in a significant number of patients on chronic medications needing to be monitored to decrease risk of adverse drug events from long-term medication use or misuse of medications. Persistent use of ACE Inhibitors or ARBs warrants monitoring and follow-up by the medical home to assess for side-effects, particularly loss of kidney function, and adjust drug dosage/therapeutic decisions accordingly.[539] The costs of annual monitoring are then offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications[540].

Process milestones were chosen to in order to insure processes are in place to successfully monitor progress. Parkland intends to promote care management and the use of the medical home model and chronic care model in all care settings and while Parkland's community-oriented primary care clinics (COPCs) are certified as medical homes under the 2008 guidelines, a readiness assessment and plan must be implemented to meet the updated 2011 guidelines. All Parkland initiatives are focused on balancing the care continuum through increased access and empaneling patients to medical home care teams and also implementing a chronic care model throughout the health system. The focus is to better serve those patients who have chronic conditions and need care teams to assist them to meet their health goals. Elements of the care model through the medical home include monitoring medications, insuring screenings and preventive services are provided and maintaining adequate communication between the care teams and the patient. This outcome is a component of the care model Parkland is implementing across the system.

Related Category 1 and/or 2 Projects

- 127295703.1.1: Establish more primary care clinics – Grand Prairie

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements

[539] Jessup, M., et al., *2009 focused update: ACCF/AHA guidelines for the diagnosis and management of heart failure in adults: a report of American College of Cardiology Foundation/American Heart Association Taks Force on Practice Guidelines: Developed in collaboration with the International Society for Heart and Lung Transplantation.* 2009. 119(14): p. 1977-2016.

[540] Briggs, A., et al., *Cost effectiveness of perindopril in reducing cardiovasular events in patients with stable coronary artery disease using data from the EUROPA study.* Heart, 2007. 93: p. 1081-1086.

127295703.3.1	*3.IT.1.2*	*Annual monitoring for patients on persistent medications – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.1.1 – Establish more primary care clinics – Grand Prairie*		
Starting Point/Baseline:		*Diabetes: 82.5% (2,282/2,766 patients); CHF: 83.7% (605/703 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment (max amount): $382,183		**Process Milestone 2** [P-2]: Establish baseline rate Use pilot test data, peer reviewed literature and consensus of adult health physicians to establish goals for DY3, DY4 and DY5 Goal: Determine baseline Data Source: Peer reviewed literature, benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $443,000	**Outcome Improvement Target 1** [IT-1.2] Annual monitoring for patients on persistent medications: ACE inhibitors or ARBs Improvement Target: 85% of eligible patients monitored during the year Baseline: Diabetes is 82.5% in FY12 (2,282/2,766); CHF is 83.7% (605/703 patients) Goal: 85% monitored Data Source: EHR, registry, report Outcome Improvement Target 1 Estimated Incentive Payment: $710,861	**Outcome Improvement Target 2** [IT-1.2] Annual monitoring for patients on persistent medications: ACE inhibitors or ARBs Improvement Target: 88% of eligible patients monitored during the year Goal: 88% monitored Data Source: EHR, registry, report Outcome Improvement Target 2 Estimated Incentive Payment: $1,699,885
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $382,183		**Year 3 Estimated Outcome Amount:** $443,000	**Year 4 Estimated Outcome Amount:** $710,861	**Year 5 Estimated Outcome Amount:** $1,699,885
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $3,235,929				

Title of Outcome Measure (Improvement Target): IT-1.12 – Diabetes Care: Retinal Eye Exam

Unique RHP outcome identification number: 127295703.3.2

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT - 1.12 - Diabetes Care: Retinal Eye Exam (NQF 0055) (Non-standalone Measure)

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: Members 18 to 75 year of age as of December 31 of the measurement year with diabetes (type 1 or type 2)

Process Milestones:

- DY2
    - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3
    - P-2: Establish a baseline rate among established patients

Outcome Improvement Targets:

- DY4:
    - IT-1.12: Increase number of COPC patients with diabetes had a retinal exam in the recommended time-frame. Improvement Target: 2,500
- DY 5:
    - IT-1.12: Increase number of COPC patients with diabetes had a retinal exam in the recommended time-frame. Improvement Target: 3,000

Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 25.8 million Americans have diabetes, of which about 7 million are undiagnosed[541]. In addition, diabetes was the seventh leading cause of death in Americans of all ages in 2009, and the fifth leading cause of death among the "young old," ages 65-79[542]. Diabetic retinopathy, one of the leading causes of blindness in adults, can be treated if detected and addressed in the early stages[543].

Process milestones were chosen to promote chronic disease management and the use of the chronic disease management mode in the primary care clinics. In DY2, we will complete the process currently under way of installing retinal scan cameras and training clinicians in their use. This will include using existing relationship between Parkland optometrists and the ophthalmology department of our clinical partner, University of Texas Southwestern Medical School. Retinal scan results will be entered into the patient's EHR record.

In DY3, we will use current data to establish a baseline from which to set goals for DY3, DY4 and DY5. Once the retinal scan cameras and the necessary clinical teams are in place and trained, we will begin routine use of the retinal cameras for diabetic eye exams, including putting retinal scan compliance in the diabetic registry, at one pilot location. At the end of the year we will compare our rate of scans to our goal, study successes and failures of process and information technology and adjust the system. In DY4 and DY5, we will roll out the system at all sites to insure identified diabetic patients have retinal eye exams. We will also study successes and failures for any potential improvements.

Related Category 1 and/or 2 Projects

- 127295703.1.1: Establish more primary care clinics – Grand Prairie

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and

[541] US Department of Health and Human Services, C.f.D.C.a.P. National Diabetes Fact Sheet 2011. 2011; Available from: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

[542] National Vital Statistics System, C.N., Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 5-year age group, by race/ sex: United States, 1999-2009, C.f.D.C.a.P. US Department of Health and Human Services, Editor 2009.

[543] American Optometric Association. Diabetes is the leading cause of blindness among most adults. 2012 [cited 2012 October 19]; Available from: http://www.aoa.org/x6814.xml.

2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

127295703.3.2	*3.IT-1.12*	*Diabetes – Retinal Eye Exam*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:	*127295703.1.1 – Establish more primary care clinics – Grand Prairie*		
Starting Point/Baseline:	*0 in FY2011*		
Year 2 (10/1/2012 – 9/30/2013)	**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 Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment: $382,183	**Process Milestone 2** [P-2]: Establish baseline rate Goal: Determine baseline Data Source: Peer-reviewed literature, national benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $443,000	**Outcome Improvement Target 1** [IT-1.12] Increase number of COPC established diabetic patients who have retinal exam in recommended time frame Improvement Target: Increase number of patients who receive retinal eye exams Baseline: 0 in FY11 Goal: 2,500 patients to have retinal eye exams Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 1 Estimated Incentive Payment: $710,860	**Outcome Improvement Target 2** [IT-1.12] Increase number of COPC established diabetic patients who have retinal exam in recommended time frame Improvement Target: Increase number of patients who receive retinal eye exams Goal: 3,000 patients to have retinal eye exams Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 2 Estimated Incentive Payment: $1,699,884
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $382,183	**Year 3 Estimated Outcome Amount:** $443,000	**Year 4 Estimated Outcome Amount:** $710,860	**Year 5 Estimated Outcome Amount:** $1,699,884
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $3,235,927			

Title of Outcome Measure (Improvement Target): IT-1.20 – Other: Preventive services for children and adolescents (ICSI/AHRQ Measure) - Recommended Adolescent Immunizations

Unique RHP outcome identification number: 127295703.3.3

Performing Provider Name/ TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-12.6: Other Outcome Improvement Target (ICSI/AHRQ Measure): Preventive services for children and adolescents: percentage of patients who by age 13 years were up-to-date with recommended adolescent immunizations: 1) one MCV4 – meningococcal, 2) one Tdap – tetanus, diphtheria toxoids and acellular pertussis vaccine within the last year (NQF Measure)

Numerator: Number of established patients ages 13-17 who received both vaccine doses

Denominator: Number of established patients ages 13-17

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 a baseline rate among established patients

Outcome Improvement Targets:

- DY4:
    - IT-12.6: Increase percentage of established pediatric patients age 13 and older who have had the recommended vaccine combination within the past year. Improvement Target: 75% compliance
        - Numerator: Established patients ages 13-17 who have received all four vaccine doses, including receiving the influenza vaccine within past year
        - Denominator: Established patients ages 13-17.

- DY 5:
    - IT-12.6: Increase percentage of established pediatric patients age 13 and older who have had the recommended vaccine combination within the past year. Improvement Target: 80% compliance
        - Numerator: Established patients ages 13-17 who have received all four vaccine doses, including receiving the influenza vaccine within past year
        - Denominator: Established patients ages 13-17.

Rationale

The Institute for Clinical Systems Improvement has made these four vaccines part of their Level I recommendations for this age group. The priority aim addressed by this measure is to increase the rate of pediatric patients up-to-date with Level I preventive services, the highest priority of clinical services[544]. The following vaccines are recommended by the American Academy of Pediatrics, the American Academy of Family Medicine, the CDC and AHRQ.

- Tdap vaccine which protects against tetanus, diphtheria and pertussis
- Meningococcal conjugate vaccine, which prevents meningococcal disease (10-14% of invasive meningococcal infections are fatal, and another 11-19% result in long-term disability such as deafness, brain damage, or an amputated arm or leg; the prevalence in of invasive meningococcal disease peaks in infants, with a second peak in adolescents

Parkland sees approximately 5,500, thirteen-year-old patients in its COPC health centers annually. Improvement in the immunization rates for this population will insure the health of our community and in decreasing illness and disability caused by these vaccine preventable conditions.

Process milestones were chosen due to insure capacity and needed resources are addressed to insure prevention measures can be taken. Improvement milestones will measure success of the process milestones.

Related Category 1 and/or 2 Projects

- 127295703.1.1: Establish more primary care clinics – Grand Prairie

Outcome Measure Valuation

[544] Wilkinson, J., Health care guideline: preventive services children and adolescents, in Level I Services, C. Bass, Editor 2012, Institute for Healthcare Improvement.

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

127295703.3.3	*3.IT-1.20*	*Other (ICSI/AHRQ Measure)-Preventive Services for Children and Adolescents: Percentage of patients who by age 13 years were up-to-date with recommended adolescent immunizations: 1) one MCV 2) one Tdap and acellular pertussis vaccine*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:	*127295703.1.1 – Establish more primary care clinics – Grand Prairie*		
Starting Point/Baseline:	*66% Compliance (1,617/2,456 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $118,106	**Process Milestone 2** [P-3]: Establish baseline rate Goal: Determine baseline Data Source: Peer-reviewed literature, national benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $136,901	**Outcome Improvement Target 1** [IT-12.6] Increase percentage of established pediatric patients age 13 and older who have recommended vaccine combination Improvement Target: 75% of patients age 13 or order receive recommended vaccine combination Baseline: 66% compliance (1,617/2,456 patients) Goal: 75% compliance Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 1 Estimated Incentive Payment*:* $219,678	**Outcome Improvement Target 2** [IT-12.6] Increase percentage of established pediatric patients age 13 and older who have recommended vaccine combination Improvement Target: 80% of patients age 13 or older receive recommended vaccine combination Goal: 80% compliance Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 2 Estimated Incentive Payment*:* $525,315
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $118,106	**Year 3 Estimated Outcome Amount:** $136,901	**Year 4 Estimated Outcome Amount:** $219,678	**Year 5 Estimated Outcome Amount:** $525,315
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,000,000			

Title of Outcome Measure (Improvement Target): IT-1.2 – Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)

Unique RHP outcome identification number: 127295703.3.4

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-1.2 - Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs). Defined as the percentage of established patients 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Numerator: Established patients from the denominator with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year

Inclusions: Established patients must meet one of the following criteria to be compliant:

- Code for a lab panel test during measurement year
- Code for serum potassium & code for serum creatinine during measurement year
- Code for serum potassium & code for blood urea nitrogen during measurement year

Note: Tests don't need to occur on same service date, only within measurement year

Denominator: Established patients 18 years of age or older as of December 31 of the measurement year on persistent angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) – defined as patients who received at least 180 treatment days of ambulatory medication during measurement year.
Inclusions: Members 18 years of age and older as of December 31 of the measurement year on persistent angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) – defined as members who received at least 180 treatment days of ambulatory medication during the measure year. Note:

- Patients must have been continuously enrolled during the measurement year.
- Allowable gap: No more than one gap in enrollment of up to 45 days during each year of continuous enrollments (commercial, Medicare). To determine continuous

enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the patient may not have more than a 1-month gap in coverage.

- Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days).
- Refer to Table CDC-L in the original measure documentation to identify ACE inhibitors and ARBs. Patients may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days supply for those medication count toward the total 180 treatment days (i.e., a patient who received 90 days of ACE inhibitors and 90 days of ARBs meet the denominator definition for measure).

Exclusions: Exclude patients who had an inpatient (acute or non-acute) claim/encounter during the measurement year.

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 a baseline rate among established patients

Outcome Improvement Targets:

- DY4
  - IT-1.2: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – ACE inhibitors or angiotensin receptor blockers (ARBs)
    - Improvement Target – CHF: 85%
    - Improvement Target – Diabetes: 85%
- DY5
  - IT-1.2: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – ACE inhibitors or angiotensin receptor blockers (ARBs)

- Improvement Target – CHF: 88%
- Improvement Target – Diabetes: 88%

Rationale

Hypertension and diabetes are two of Parkland's most common diagnoses, resulting in a significant number of patients on chronic medications needing to be monitored to decrease risk of adverse drug events from long-term medication use or misuse of medications. Persistent use of ACE Inhibitors or ARBs warrants monitoring and follow-up by the medical home to assess for side-effects, particularly loss of kidney function, and adjust drug dosage/therapeutic decisions accordingly.[545] The costs of annual monitoring are then offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications[546].

Process milestones were chosen to in order to insure processes are in place to successfully monitor progress. Parkland intends to promote care management and the use of the medical home model and chronic care model in all care settings and while Parkland's community-oriented primary care clinics (COPCs) are certified as medical homes under the 2008 guidelines, a readiness assessment and plan must be implemented to meet the updated 2011 guidelines. All Parkland initiatives are focused on balancing the care continuum through increased access and empaneling patients to medical home care teams and also implementing a chronic care model throughout the health system. The focus is to better serve those patients who have chronic conditions and need care teams to assist them to meet their health goals. Elements of the care model through the medical home include monitoring medications, insuring screenings and preventive services are provided and maintaining adequate communication between the care teams and the patient. This outcome is a component of the care model Parkland is implementing across the system.

Related Category 1 and/or 2 Projects

- 127295703.1.2: Expand current capacity of primary care clinics

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score

[545] Jessup, M., et al., *2009 focused update: ACCF/AHA guidelines for the diagnosis and management of heart failure in adults: a report of American College of Cardiology Foundation/American Heart Association Taks Force on Practice Guidelines: developed in collaboration with the International Society for Heart and Lung Transplantation.* 2009. 119(14): p. 1977-2016.

[546] Briggs, A., et al., *Cost effectiveness of perindopril in reducing cardiovasular events in patients with stable coronary artery disease using data from the EUROPA study.* Heart, 2007. 93: p. 1081-1086.

provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

127295703.3.4	*3.IT.1.2*	*Annual monitoring for patients on persistent medications – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.1.2 – Expand existing primary care capacity*		
Starting Point/Baseline:		*Diabetes: 82.5% (2,282/2,766 patients); CHF: 83.7% (605/703 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment (max amount): $254,170		**Process Milestone 2** [P-2]: Establish baseline rate Use pilot test data, peer reviewed literature and consensus of adult health physicians to establish goals for DY3, DY4 and DY5 Goal: Determine baseline Data Source: Peer reviewed literature, benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $294,617	**Outcome Improvement Target 1** [IT-1.2] Annual monitoring for patients on persistent medications –ACE inhibitors or angiotensin receptor blockers (ARBs) Improvement Target: 85% percent of eligible patients monitored during year Baseline: Diabetes is 82.5% (2,282/ 2,766); CHF is 83.7% (605/703) Goal: 85% monitored Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 1 Estimated Incentive Payment*:* $472,757	**Outcome Improvement Target 2** [IT-1.2] Annual monitoring for patients on persistent medications – ACE inhibitors or angiotensin receptor blockers (ARBs). Improvement Target: 88% of eligible patients monitored during the year Goal: 88% monitored Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,130,505
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $254,170		**Year 3 Estimated Outcome Amount:** $294,617	**Year 4 Estimated Outcome Amount:** $472,757	**Year 5 Estimated Outcome Amount:** $1,130,505
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,152,049				

Title of Outcome Measure (Improvement Target): IT-1.12 – Diabetes Care: Retinal Eye Exam

Unique RHP outcome identification number: 127295703.3.5

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT - 1.12 - Diabetes Care: Retinal Eye Exam (NQF 0055) (Non-standalone Measure)

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: Members 18 to 75 year of age as of December 31 of the measurement year with diabetes (type 1 or type 2)

Process Milestones:

- DY2:
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2: Establish a baseline rate among established patients

Outcome Improvement Targets:

- DY4:
  - IT-1.12: Increase number of COPC patients with diabetes had a retinal exam in the recommended time-frame. Improvement Target: 2,500
- DY 5:
  - IT-1.12: Increase number of COPC patients with diabetes had a retinal exam in the recommended time-frame. Improvement Target: 3,000

Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 25.8 million Americans have diabetes, of which about 7 million are undiagnosed[547]. In addition, diabetes was the seventh leading cause of death in Americans of all ages in 2009, and the fifth leading cause of death among the "young old," ages 65-79[548]. Diabetic retinopathy, one of the leading causes of blindness in adults, can be treated if detected and addressed in the early stages[549].

Process milestones were chosen due to promote chronic disease management and the use of the chronic disease management mode in the primary care clinics. In DY2, we will complete the process currently under way of installing retinal scan cameras and training clinicians in their use. This will include using existing relationship between Parkland optometrists and the ophthalmology department of our clinical partner, University of Texas Southwestern Medical School. Retinal scan results will be entered into the patient's EHR record.

In DY3, we will use current data to establish a baseline from which to set goals for DY3, DY4 and DY5. Once the retinal scan cameras and the necessary clinical teams are in place and trained, we will begin routine use of the retinal cameras for diabetic eye exams, including putting retinal scan compliance in the diabetic registry, at one pilot location. At the end of the year we will compare our rate of scans to our goal, study successes and failures of process and information technology and adjust the system. In DY4 and DY5, we will roll out the system at all sites to insure identified diabetic patients have retinal eye exams. We will also study successes and failures for any potential improvements.

Related Category 1 and/or 2 Projects

- 127295703.1.2: Expand existing primary care capacity

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

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[547] US Department of Health and Human Services, C.f.D.C.a.P. National Diabetes Fact Sheet 2011. 2011; Available from: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

[548] National Vital Statistics System, C.N., Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 5-year age group, by race/sex: US, 1999-2009, C.f.D.C.a.P. US Department of Health and Human Services, Editor 2009.

[549] American Optometric Association. Diabetes is the leading cause of blindness among most adults. 2012 [cited 2012 October 19]; Available from: http://www.aoa.org/x6814.xml.

127295703.3.5	*3.IT-1.12*	*Diabetes – Retinal Eye Exam*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:	*127295703.1.2 – Expand existing primary care capacity*		
Starting Point/Baseline:	*0 in FY2011*		
Year 2 (10/1/2012 – 9/30/2013)	**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 Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment: $254,170	**Process Milestone 2** [P-2]: Establish a baseline rate Goal: Determine baseline Data Source: Peer-reviewed literature, national benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $294,616	**Outcome Improvement Target 1** [IT-1.12] Increase number of established diabetic patients who have retinal exam in the recommended time frame. Improvement Target: 2,500 patients to receive retinal eye exam Baseline: 0 in FY11 Goal: 2,500 patients to have retinal eye exams Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 1 Estimated Incentive Payment: $472,756	**Outcome Improvement Target 2** [IT-1.12] Increase number of established diabetic patients who have had retinal exam in the recommended time frame Improvement Target: 3,000 patients to receive retinal eye exam Goal: 3,000 patients to have retinal eye exams Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 2 Estimated Incentive Payment: $1,130,504
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $254,170	Year 3 Estimated Outcome Amount: $294,616	Year 4 Estimated Outcome Amount: $472,756	Year 5 Estimated Outcome Amount: $1,130,504
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,152,046			

Title of Outcome Measure (Improvement Target): IT-1.20 – Other: Preventive services for children and adolescents (ICSI/AHRQ Measure) – Recommended Adolescent Immunizations

Unique RHP outcome identification number: 127295703.3.6

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Description

IT-12.6: Other Outcome Improvement Target (ICSI/AHRQ Measure): Preventive services for children and adolescents: percentage of patients who by age 13 years were up-to-date with recommended adolescent immunizations: 1) one MCV4 – meningococcal, 2) one Tdap – tetanus, diphtheria toxoids and acellular pertussis vaccine within the last year (NQF Measure)

Numerator: Number of established patients ages 13-17 who received both vaccine doses

Denominator: Number of established patients ages 13-17

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 a baseline rate among established patients

Outcome Improvement Targets:

- DY4:
    - IT-12.6: Increase percentage of established pediatric patients age 13 and older who have had the recommended vaccine combination within past year. Improvement Target: 75% compliance
        - Numerator: Established patients ages 13-17 who have received all four vaccine doses, including receiving the influenza vaccine within past year
        - Denominator: Established patients ages 13-17.

- DY 5:
    - IT-12.6: Increase percentage of established pediatric patients age 13 and older who have had the recommended vaccine combination within past year
      Improvement Target: 80% compliance
        - Numerator: Established patients ages 13-17 who have received all four vaccine doses, including receiving the influenza vaccine within past year
        - Denominator: Established patients ages 13-17.

Rationale

The Institute for Clinical Systems Improvement has made these four vaccines part of their Level I recommendations for this age group. The priority aim addressed by this measure is to increase the rate of pediatric patients up-to-date with Level I preventive services, the highest priority of clinical services[550]. The following vaccines are recommended by the American Academy of Pediatrics, the American Academy of Family Medicine, the CDC and AHRQ.

- Tdap vaccine which protects against tetanus, diphtheria and pertussis
- Meningococcal conjugate vaccine, which prevents meningococcal disease (10-14% of invasive meningococcal infections are fatal, and another 11-19% result in long-term disability such as deafness, brain damage, or an amputated arm or leg; prevalence of invasive meningococcal disease peaks in infants, with a second peak in adolescents

Parkland sees approximately 5,500, thirteen-year-old patients in its COPC health centers annually. Improvement in the immunization rates for this population will insure the health of our community and in decreasing illness and disability caused by these vaccine preventable conditions.

Process milestones were chosen due to insure capacity and needed resources are addressed to insure prevention measures can be taken. Improvement milestones will measure success of the process milestones.

Related Category 1 and/or 2 Projects

- 127295703.1.2: Expand existing primary care capacity

Outcome Measure Valuation

[550] Wilkinson, J., Health care guideline: preventive services children and adolescents, in Level I Services, C. Bass, Editor 2012, Institute for Healthcare Improvement.

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

127295703.3.6	*3.IT-1.20*	*Other (ICSI/AHRQ Measure)-Preventive Services for Children and Adolescents: Percentage of patients who by age 13 years were up-to-date with recommended adolescent immunizations: 1) one MCV 2) one Tdap and acellular pertussis vaccine*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.1.2 – Expand existing primary care capacity*		
Starting Point/Baseline:		*66% Compliance (1,617/2,456 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $118,106		**Process Milestone 2** [P-3]: Establish baseline rate Data Source: Peer-reviewed literature, national benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $136,900	**Outcome Improvement Target 1** [IT-12.6] Increase percentage of established pediatric patients age 13 and older who have recommended vaccine combination Improvement Target: 75% of patients age 13 and older who receive vaccine combination Baseline: 66% compliance (1,617/ 2,456 patients) Goal: 75% compliance Data Source: EHR, registry, report Outcome Improvement Target 1 Estimated Incentive Payment: $219,678	**Outcome Improvement Target 2** [IT-12.6] Increase percentage of established pediatric patients age 13 and older who have recommended vaccine combination Improvement Target: 80% of patients age 13 and older who receive vaccine combination Goal: 80% compliance Data Source: EHR, registry, report Outcome Improvement Target 2 Estimated Incentive Payment: $525,316
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $118,106		**Year 3 Estimated Outcome Amount:** $136,900	**Year 4 Estimated Outcome Amount:** $219,678	**Year 5 Estimated Outcome Amount:** $525,316
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,000,000				

Title of Outcome Measure (Improvement Target): IT-1.2 – Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)

Unique RHP outcome identification number: 127295703.3.7

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-1.2 - Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)

Defined as the percentage of established patients 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Numerator: Established patients from the denominator with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year
Inclusions: Established patients must meet one of the following criteria to be compliant:

- Code for a lab panel test during measurement year
- Code for serum potassium & code for serum creatinine during measurement year
- Code for serum potassium & code for blood urea nitrogen during measurement year

Note: Tests don't need to occur on same service date, only within measurement year

Denominator: Established patients 18 years of age or older as of December 31 of the measurement year on persistent angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) – defined as patients who received at least 180 treatment days of ambulatory medication during measurement year.
Inclusions: Members 18 years of age and older as of December 31 of the measurement year on persistent angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) – defined as members who received at least 180 treatment days of ambulatory medication during the measure year. Note:

- Patients must have been continuously enrolled during the measurement year.
- Allowable gap: No more than one gap in enrollment of up to 45 days during each year of continuous enrollments (commercial, Medicare). To determine continuous

enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the patient may not have more than a 1-month gap in coverage.

- Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days).

- Refer to Table CDC-L in the original measure documentation to identify ACE inhibitors and ARBs. Patients may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days supply for those medication count toward the total 180 treatment days (i.e., a patient who received 90 days of ACE inhibitors and 90 days of ARBs meet denominator definition for this measure).

Exclusions: Exclude patients who had an inpatient (acute or non-acute) claim/encounter during the measurement year.

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 a baseline rate among established patients

Outcome Improvement Targets:

- DY4
    - IT-1.2: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – ACE inhibitors or angiotensin receptor blockers (ARBs)
        - Improvement Target – CHF: 85%
        - Improvement Target – Diabetes: 85%
- DY5
    - IT-1.2: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – ACE inhibitors or angiotensin receptor blockers (ARBs)
        - Improvement Target – CHF: 88%
        - Improvement Target – Diabetes: 88%

Rationale

Hypertension and diabetes are two of Parkland's most common diagnoses, resulting in a significant number of patients on chronic medications needing to be monitored to decrease risk of adverse drug events from long-term medication use or misuse of medications. Persistent use of ACE Inhibitors or ARBs warrants monitoring and follow-up by the medical home to assess for side-effects, particularly loss of kidney function, and adjust drug dosage/therapeutic decisions accordingly.[551] The costs of annual monitoring are then offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications[552].

Process milestones were chosen to in order to insure processes are in place to successfully monitor progress. Parkland intends to promote care management and the use of the medical home model and chronic care model in all care settings and while Parkland's community-oriented primary care clinics (COPCs) are certified as medical homes under the 2008 guidelines, a readiness assessment and plan must be implemented to meet the updated 2011 guidelines. All Parkland initiatives are focused on balancing the care continuum through increased access and empaneling patients to medical home care teams and also implementing a chronic care model throughout the health system. The focus is to better serve those patients who have chronic conditions and need care teams to assist them to meet their health goals. Elements of the care model through the medical home include monitoring medications, insuring screenings and preventive services are provided and maintaining adequate communication between the care teams and the patient. This outcome is a component of the care model Parkland is implementing across the system.

Related Category 1 and/or 2 Projects

- 127295703.1.3: Implement chronic disease registry

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

[551] Jessup, M., et al., *2009 focused update: ACCF/AHA guidelines for the diagnosis and management of heart failure in adults: a report of American College of Cardiology Foundation/American Heart Association Taks Force on Practice Guidelines: developed in collaboration with the International Society for Heart and Lung Transplantation.* 2009. 119(14): p. 1977-2016.

[552] Briggs, A., et al., *Cost effectiveness of perindopril in reducing cardiovasular events in patients with stable coronary artery disease using data from the EUROPA study*. Heart, 2007. **93**: p. 1081-1086.

127295703.3.7	*3.IT.1.2*	*Annual monitoring for patients on persistent medications – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.1.3 – Implement chronic care disease registry*		
Starting Point/Baseline:		*Diabetes: 82.5% (2,282/2,766 patients); CHF: 83.7% (605/703 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment (max amount): $277,815		**Process Milestone 2** [P-2]: Establish baseline rate Use pilot test data, peer reviewed literature and consensus of adult health physicians to establish goals for DY3, DY4 and DY5 Goal: Determine baseline Data Source: Peer reviewed literature, benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $322,024	**Outcome Improvement Target 1** [IT-1.2] Annual monitoring for patients on persistent medications – ACE inhibitors or angiotensin receptor blockers (ARBs) Improvement Target: 85% percent of eligible patients monitored during year FY12 Baseline: Diabetes is 82.5% (2,282/2,766 patients); CHF is 83.7% (605/703 patients Goal: 85% monitored Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 1 Estimated Incentive Payment: $516,737	**Outcome Improvement Target 2** [IT-1.2] Annual monitoring for patients on persistent medications –ACE inhibitors or angiotensin receptor blockers (ARBs) Improvement Target: 88% percent of eligible patients monitored during year Goal: 88% monitored Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 2 Estimated Incentive Payment: $1,235,675
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $277,815		**Year 3 Estimated Outcome Amount:** $322,024	**Year 4 Estimated Outcome Amount:** $516,737	**Year 5 Estimated Outcome Amount:** $1,235,675
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,352,251				

Title of Outcome Measure (Improvement Target): IT-1.12 – Diabetes Care: Retinal Eye Exam

Unique RHP outcome identification number: 127295703.3.8

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT - 1.12 - Diabetes Care: Retinal Eye Exam (NQF 0055) (Non-standalone Measure)

Numerator: An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

a) A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, or

b) A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year

Denominator: Members 18 to 75 year of age as of December 31 of the measurement year with diabetes (type 1 or type 2)

Process Milestones:

- DY2:
    - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
    - P-2: Establish a baseline rate among established patients

Outcome Improvement Targets:

- DY4:
    - IT-1.12: Increase number of COPC patients with diabetes had a retinal exam in the recommended time-frame. Improvement Target: 2,500
- DY 5:
    - IT-1.12: Increase number of COPC patients with diabetes had a retinal exam in the recommended time-frame. Improvement Target: 3,000

Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 25.8 million Americans have diabetes, of which about 7 million are undiagnosed[553]. In addition, diabetes was the seventh leading cause of death in Americans of all ages in 2009, and the fifth leading cause of death among the "young old," ages 65-79[554]. Diabetic retinopathy, one of the leading causes of blindness in adults, can be treated if detected and addressed in the early stages[555].

Process milestones were chosen due to promote chronic disease management and the use of the chronic disease management mode in the primary care clinics. In DY2, we will complete the process currently under way of installing retinal scan cameras and training clinicians in their use. This will include using existing relationship between Parkland optometrists and the ophthalmology department of our clinical partner, University of Texas Southwestern Medical School. Retinal scan results will be entered into the patient's EHR record.

In DY3, we will use current data to establish a baseline from which to set goals for DY3, DY4 and DY5. Once the retinal scan cameras and the necessary clinical teams are in place and trained, we will begin routine use of the retinal cameras for diabetic eye exams, including putting retinal scan compliance in the diabetic registry, at one pilot location. At the end of the year we will compare our rate of scans to our goal, study successes and failures of process and information technology and adjust the system. In DY4 and DY5, we will roll out the system at all sites to insure identified diabetic patients have retinal eye exams. We will also study successes and failures for any potential improvements.

Related Category 1 and/or 2 Projects

- 127295703.1.3: Implement chronic disease registry

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

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[553] US Department of Health and Human Services, C.f.D.C.a.P. National Diabetes Fact Sheet 2011. 2011; Available from: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

[554] National Vital Statistics System, C.N., Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 5-year age group, by race/ sex: US, 1999-2009, C.f.D.C.a.P. US Department of Health and Human Services, Editor 2009.

[555] American Optometric Association. Diabetes is the leading cause of blindness among most adults. 2012 [cited 2012 October 19]; Available from: http://www.aoa.org/x6814.xml.

127295703.3.8	*3.IT-1.12*	*Diabetes – Retinal Eye Exam*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:	*127295703.1.3 – Implement Chronic Care Registry*		
Starting Point/Baseline:	*0 in FY2011*		
Year 2 (10/1/2012 – 9/30/2013)	**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 Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment: $277,815	**Process Milestone 2** [P-2]: Establish baseline rate Goal: Determine baseline Data Source: Peer-reviewed literature, national benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $322,024	**Outcome Improvement Target 1** [IT-1.12] Increase number of established diabetic patients who have retinal exam in recommended time frame Improvement Target: 2,500 diabetic patients have retinal eye exams Baseline: 0 in FY2011 Goal: 2,500 patients to have retinal eye exam Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 1 Estimated Incentive Payment*:* $516,737	**Outcome Improvement Target 2** [IT-1.12] Increase number of established diabetic patients who have had retinal exam in recommended time frame Improvement Target: 3,000 diabetic patients have retinal eye exam Goal: 3,000 patients to have retinal eye exam Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,235,675
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/ outcome improvement target): $277,815	**Year 3 Estimated Outcome Amount:** $322,024	**Year 4 Estimated Outcome Amount:** $516,737	**Year 5 Estimated Outcome Amount:** $1,235,675
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,352,251			

Title of Outcome Measure (Improvement Target): IT-3.3 – Diabetes 30-day Readmission Rate

Unique RHP outcome identification number(s): 127295703.3.9

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-3.3 – Diabetes 30-day Readmission Rate (Standalone Measure)

> **Numerator:** The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
>
> **Denominator:** The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

Process Milestones

- DY2:
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, document implementation plans
  - P-2: Establish baseline rates
- DY3:
  - P-4: Conduct PDSA cycle to improve data collection & intervention activities
  - P-5: Disseminate findings, including best practices and lessons learned

Outcome Improvement Targets for each year

- DY4:
  - IT-3.2 – Diabetes 30-day Readmission Rate. Improvement target: 9.0%
- DY5:
  - IT-3.2 – Diabetes 30-day Readmission Rate. Improvement target: 8.7%

Rationale

As the Planning Protocol Category 3 restates, the relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay.[556]

[556] Goldfield N, McCullough E, Hughes, Tang A, Eastman B, Rawlins L, Averill R. 2008. "Identifying Potentially Preventable Readmissions." *Health Care Financing Review*. 30:1; pp75 -91.

Parkland intends to conduct performance improvement projects using PI methodologies to improve readmission rates such as All Cause, AMI and Diabetes (CHF readmissions have already been improved significantly). One of the initiatives to improve readmissions is to implement an effective discharge planning process which is another of Parkland's key objectives.

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 25.8 million Americans have diabetes, and about 7 million of these cases are undiagnosed[557]. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes was the seventh leading cause of death in Americans of all ages in 2009, and the fifth leading cause of death among the "young old," ages 65-79[558].

Work has begun to develop the appropriate clinical protocols and chronic care management model to care for patients with conditions such as diabetes. Several projects are focused on diabetes outcomes to insure that efforts across the continuum are focused. It is important to insure that patients are identified and followed throughout the care process to insure effective chronic care management.

To appropriately understand the causes for readmissions, a plan must be developed, which will be addressed in DY2 with findings disseminated in DY3. In DY2 we will also establish the baseline and in DY3, we will conduct a PDSA cycle. Improvement targets will determine success of interventions.

Related Category 1 and/or 2 Projects

- 127295703.1.3: Implement Chronic Care Registry

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

[557] US Department of Health and Human Services, C.f.D.C.a.P. *National Diabetes Fact Sheet 2011*. 2011; Available from: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

[558] National Vital Statistics System, C.N., *Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 5-year age group, by race and sex: United States, 1999-2009*, C.f.D.C.a.P. US Dept of Health and Human Services, Editor 2009.

127295703.3.9	*3.IT-3.3*	*Diabetes 30-Day Readmission Rate*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:		*127295703.1.3 – Implement Chronic Care Registry*	
Starting Point/Baseline:		*9.2% (117/1,272 diabetic 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-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation of plan Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment (max amount): $138,908 **Process Milestone 2** [P-2]: Establish baseline rates Goal: Determine baseline Data Source: Peer-reviewed literature, national benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment (max amount): $138,908		**Process Milestone 3** [P-4]: Conduct PDSA cycle Goal: Conduct PDSA cycle Data Source: PDSA cycle documentation Process Milestone 3 Estimated Incentive Payment (max amount): $161,012 **Process Milestone 4** [P-5] Disseminate findings, including best practices and lessons learned Goal: Summarize findings Data Source: Complete plan, report Process Milestone 4 Estimated Incentive Payment (max amount): $161,013	**Outcome Improvement Target 1** [IT-3.3]: Diabetes 30-day Readmissions Rate Improvement Target: Improve diabetes 30-day readmissions rate to 9.0% Baseline: 9.2% (117/1,272 diabetic readmissions) Goal: 9.0% readmissions rate Data Source: EHR, Claims, Benchmark Report, Documentation Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $516,736	**Outcome Improvement Target 2** [IT-3.3]: Diabetes 30-day Readmissions Rate Improvement Target: Improve diabetes 30-day readmissions rate from 9.0% in DY4 to 8.7% Goal: 8.7% readmissions rate Data Source: EHR, Claims, Benchmark Report, Documentation Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $1,235,675
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $277,816		**Year 3 Estimated Outcome Amount:** $322,025	**Year 4 Estimated Outcome Amount:** $516,736	**Year 5 Estimated Outcome Amount:** $1,235,674
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $2,352,251				

Title of Outcome Measure (Improvement Target): IT-9.2 – ED Appropriate Utilization

Unique RHP outcome identification number(s): 127295703.3.10

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-9.2: ED Appropriate Utilization for targeted patients: Specialty Care (Standalone Measure)

- Reduce all ED visits - to the Main Emergency Department for patients presenting with low acuity conditions as measured by an ESI level assignment of 4 or 5

This measure reflects the inappropriate use of scarce and costly health care resources for conditions that could be appropriately seen in a lower cost setting. Reduction of low acuity ED volume will serve as an indicator that the Parkland and RHP 9 waiver projects are achieving transformational performance.

Process Milestones

- DY2:
  - P-1: Project Planning & expansion – conduct needs assessment, develop risk tool, engage stakeholders, identify and establish high risk registry, determine timelines and document implementation plans
  - P-2: Establish baseline rate
- DY3:
  - P-5: Disseminate findings including lessons learned and best practices
  - P-7: Implement strategies to target ED readmissions for identified specialty care

Outcome Improvement Targets for each year

- DY4:
  - IT-9.2: ED Appropriate Utilization. Improvement Target: Reduce the proportion of patients presenting in the Parkland Main ED to 23%
- DY5:
  - IT-9.2: ED Appropriate Utilization. Improvement Target: Reduce the proportion of patients presenting in the Parkland Main ED to 20%

Rationale

Emergency department use for non-emergency care and repeat use for unresolved conditions is neither desirable for the hospital, or the patient. Episodic ED care lacks the benefits from the continuity of care of a primary care physician, and is costly to provide in the acute resource setting of the hospital ED. Nevertheless, hospitals continue to struggle with providing care to increasing numbers of vulnerable adults who use them as their primary source of health care. The development of patient navigation programs have emerged as a means of coordinating fragmented care, identifying gaps in care, and facilitating patient access to appropriate follow-up care settings. As a result, these programs are expected to reduce the number of patients who have had ED re-admissions

Process milestones were chosen due to the lack of current and accurate data reports regarding -ED utilization in relation to specialty care access. To appropriately understand the causes for ED utilization, a gap analysis was developed and appropriate clinic and ED leadership will determine an appropriate plan, establish a baseline and targets to be achieved in DY4 and DY5.

The improvement targets were chosen based on the timeframe allowed to develop the plan and determine processes needed to collect and report data accurately.

Related Category 1 or 2 Project(s)

- 127295703.1.4: Enhance Performance Improvement and Reporting Capacity

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

127295703.3.10	*3.IT-9.2*	*ED Appropriate Utilization*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:		*127295703.1.4 – Enhance Performance Improvement and Reporting Capacity*	
Starting Point/Baseline:		*FY 2011 – (33,236 / 87,782) = 27.5%*	
Year 2 (10/1/2012 – 9/30/2013)	**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 of plan Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment (max amount): $468,473 **Process Milestone 2** [P-2]: Establish baseline rates Goal: Determine baseline Data Source: Evidence-based literature, other documentation Process Milestone 2 Estimated Incentive Payment (max amount): $468,473	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices Goal: Summarize findings and implement strategies Data Source: Complete plan, report Process Milestone 3 Estimated Incentive Payment (max amount): $543,021 **Process Milestone 4** [P-7]: Implement strategies to reduce unnecessary ED utilization Goal: Summarize findings and implement strategies Data Source: Complete plan, documentation of milestones Process Milestone 4 Estimated Incentive Payment (max amount): $543,022	**Outcome Improvement Target 1** [IT-9.2] ED Appropriate Utilization Improvement Target: Baseline: FY 2011 – 27.5% Goal: 23.0% Numerator: Number of Patients assigned an ESI Level of 4 or 5 at triage on presentation to the Main ED Denominator: All Patients triaged on presentation to the Main ED Data Source: EHR, Claims, ED Documentation Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $1,742,720	**Outcome Improvement Target 2** [IT-9.2] ED Appropriate Utilization Improvement Target: Goal: 20.0% Numerator: Number of Patients assigned and ESI Level of 4 or 5 at triage on presentation to the Main ED Denominator: All Patients triaged on presentation to the Main ED Data Source: EHR, Claims, ED Documentation Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $4,167,373
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $936,946	**Year 3 Estimated Outcome Amount:** $1,086,043	**Year 4 Estimated Outcome Amount:** $1,742,720	**Year 5 Estimated Outcome Amount:** $4,167,373

127295703.3.10	*3.IT-9.2*	*ED Appropriate Utilization*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.1.4 – Enhance Performance Improvement and Reporting Capacity*		
Starting Point/Baseline:		*FY 2011 – (33,236 / 87,782) = 27.5%*		
Year 2 (10/1/2012 – 9/30/2013)		**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 Years 2-5): $ 7,933,082				

Title of Outcome Measure (Improvement Target): IT-1.1 – Third Next Available Appointment – Specialty Care

Unique RHP outcome identification number: 127295703.3.13

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT - 1.1 – Third Next Available Appointment (Non-standalone Measure)

Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department.

Denominator: This measure applies to providers within a reported clinic and/or department

Inclusions: This measure applies to providers* within a reported clinic and/or department**

*Providers:

A. All providers are included. Full-time and part-time providers are included, regardless of the number of hours s/he practices per week.
    1. Providers who truly job share are counted as one provider (i.e., they share one schedule, and/or they work separate day and share coverage of one practice).
    2. When measuring a care team, each member of the care team is counted separately (i.e., MD, NP, PA).
    3. If a provider is practicing in a specialty other than the one which s/he is board certified, the provider should be included in the specialty in which s/he is practicing.
    4. For providers practicing at more than 1 location, measure days to third next available for only the provider's primary location as long as the provider is at that location 51%+ of their time.
    5. New providers who started seeing patients during the reporting period and have an active schedule should be included.
B. Locums are included in the measure only if they are assigned to a specific site for an extended period of time (4+ weeks) & provide continuity care to patient panel
C. Mid-Level providers are included in the measure (NP, PA, CNM).
    1. Mid-Level providers should have continuity practice and their own schedule available to see patients.

D. Resident Providers are to be included if they have an active schedule AND are considered a Primary Care Provider within the organization.
E. Providers with closed practices should be included. They still have to schedule their current patients. It may not be clear when they see new patients again.

**Departments:

1. Primary Care
    a. General Internal Medicine
    b. Family Practice
    c. Pediatrics with the focus on generalists, not specialists
    d. Med/Peds (physicians who see both adults and children)
2. Specialty Care
    a. Obstetrics (Physical exam - New OB visit)

Exclusions:

- Exclude clinicians who do not practice for an extended period of time (greater than 4 weeks) due to maternity leave, sabbatical, family medical leave.
- Mid-Level providers who function only as an "extender," overflow to another practice, or urgent care should not be included.
- Exclude Resident Providers if they are not considered a Primary Care Provider, have an inconsistent schedule, and a restricted patient panel.

Data Collection: Sample all physicians on team the same day of the week, once a week. Count the number of days between a request for an appointment (e.g., enter dummy patient) with a physician and the third next available appointment for a new patient physical, routine exam, or return visit exam. Report the average number of days for all physicians sampled. Note: Count calendar days (e.g. include weekends) and days off. Do not count any saved appointments for urgent visits (since they are "blocked off" on the schedule.) The data collection can be done manually or electronically. Manual collection means looking in the schedule book and counting from the "index" (day when "dummy" appointment is requested) to day of third available appointment. Some electronic scheduling systems can be programmed to compute number of days automatically.

Process Milestones:

- DY2:
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish baseline

- P-5: Disseminate findings, including lessons learned and best practices

- DY3:
  - P-7: Implement strategies to improve access to specialty care services

Outcome Improvement Targets:

- DY4:
  - IT-1.1: Third next available appointment. Improvement Targets (in days):
    - Ophthalmology: 147
    - General Surgery: 227
    - Gen Surgery Evaluation: 112
    - Dermatology: 180
- DY5:
  - IT-1.1: Third next available appointment. Improvement Targets (in days):
    - Ophthalmology: 132
    - General Surgery: 205
    - Gen Surgery Evaluation: 101
    - Dermatology: 162

Rationale

Access is a measure of the patient's ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit. Counting the third next available appointment is the healthcare industry's standard measure of access to care and indicates how long a patient waits to be seen. Access to healthcare is important to the quality of healthcare outcomes. Patients who can promptly schedule appointments with their healthcare providers will have higher satisfaction, will likely return to work sooner, and may have better medical outcomes.

Related Category 1 or 2 Projects

- 127295703.1.5: Expand specialty care capacity

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and

2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

127295703.3.13	*3.IT-1.1*	*Third Next Available Appointment*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:	*127295703.1.5 – Expand Specialty Care Capacity*		
Starting Point/Baseline:	*To be determined in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Complete a planning process in order to do appropriate planning for the implementation of major infrastructure development or process redesign. Goal: Develop plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment: $177,040 **Process Milestone 2** [P-2] Establish baseline rate Goal: Determine baseline Data Source: Evidence-based literature, other documentation Process Milestone 2 Estimated Incentive Payment: $177,039	**Process Milestone 3** [P-5] Disseminate findings including lessons learned and best practices Goal: Summarize findings Data Source: Findings report Process Milestone 3 Estimated Incentive Payment: $205,212 **Process Milestone 4** [P-7] Implement strategies to improve access to specialty care services Goal: Implement strategies Data Source: Implementation plan and documentation of milestones Process Milestone 4 Estimated Incentive Payment: $205,213	**Outcome Improvement Target 1** [IT-1.1]: Third next available appointment Improvement Target: Reduce wait time for 3rd next available appointment to xx days <u>Baselines/Goals in Days</u>: Ophthalmology: 181/147 General Surgery: 280/227 Gen Surgery Evaluation: 138/112 Dermatology: 211/180 Data Source: Scheduling report Outcome Improvement Target 1 Estimated Incentive Payment*:* $658,586	**Outcome Improvement Target 2** [IT-1.1]: Third next available appointment Improvement Target: Reduce wait time for 3rd next available appointment to xx days <u>Goals in Days</u>: Ophthalmology: 132 General Surgery: 205 Gen Surgery Evaluation: 101 Dermatology: 162 Data Source: Scheduling report Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,574,880
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $354,079	**Year 3 Estimated Outcome Amount:** $410,423	**Year 4 Estimated Outcome Amount:** $658,586	**Year 5 Estimated Outcome Amount**: $1,574,880
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,997,968			

Title of Outcome Measure (Improvement Target): IT-9.2 – ED Appropriate Utilization – Specialty Care

Unique RHP outcome identification number(s): 127295703.3.14

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-9.2: ED Appropriate Utilization for targeted patients: Specialty Care – Medicine Clinics (Standalone Measure)

- Reduce ED visits for target conditions for patients who received navigation services
    - Congestive Heart Failure
    - Diabetes
    - End Stage Renal Disease
    - Cardiovascular Disease/Hypertension
    - Behavioral Health/Substance Abuse
    - Chronic Obstructive Pulmonary Disease
    - Asthma

Process Milestones

- DY2:
    - P-1: Project Planning & expansion – conduct needs assessment, develop risk tool, engage stakeholders, identify and establish high risk registry, determine timelines and document implementation plans
    - P-2: Establish baseline rate
- DY3:
    - P-5: Disseminate findings including lessons learned and best practices
    - P-7: Implement strategies to target ED readmissions for identified specialty care

Outcome Improvement Targets for each year

- DY4:
    - IT-9.2: ED Appropriate Utilization. Improvement Target: Reduce number of unnecessary ED visits for those patients receiving specialty services that have been identified for improvement in gap analysis by 10% from baseline

- DY5:
    - IT-9.2: ED Appropriate Utilization. Improvement Target: Reduce number of unnecessary ED visits for those patients receiving specialty services that have been identified for improvement in gap analysis by 15% from baseline

Rationale

Emergency department use for non-emergency care and repeat use for unresolved conditions is neither desirable for the hospital, or the patient. Episodic ED care lacks the benefits from the continuity of care of a primary care physician, and is costly to provide in the acute resource setting of the hospital ED. Nevertheless, hospitals continue to struggle with providing care to increasing numbers of vulnerable adults who use them as their primary source of health care. The development of patient navigation programs have emerged as a means of coordinating fragmented care, identifying gaps in care, and facilitating patient access to appropriate follow-up care settings. As a result, these programs are expected to reduce the number of patients who have had ED re-admissions

Process milestones were chosen due to the lack of current and accurate data reports regarding -ED utilization in relation to specialty care access. To appropriately understand the causes for ED utilization, a gap analysis was developed and appropriate clinic and ED leadership will determine an appropriate plan, establish a baseline and targets to be achieved in DY4 and DY5.

The improvement targets were chosen based on the timeframe allowed to develop the plan and determine processes needed to collect and report data accurately.

Related Category 1 or 2 Project

- 127295703.1.5: Expand Specialty Care Capacity

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

127295703.3.14	*3.IT-9.2*	*ED Appropriate Utilization*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:	*127295703.1.5 – Expand Specialty Care Capacity*		
Starting Point/Baseline:	*7,198 visits to ED (for patients from specified 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]: Project Planning & expansion – conduct needs assessment, develop risk tool, engage stakeholders, determine timelines and document implementation plan Goal: Develop plan Data Source: Project plan documentation Process Milestone 1 Estimated Incentive Payment*:* $177,039 **Process Milestone 2** [P-2]: Establish baseline rate Goal: Determine baseline Data Source: Evidence-based literature, other documentation Process Milestone 2 Estimated Incentive Payment*:* $177,039	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices to stakeholders Goal: Summarize findings Data Source: Documentation of findings Process Milestone 3 Estimated Incentive Payment: $205,212 **Process Milestone 4** [P-7]: Implement strategies to reduce ED overutilization Goal: Implement strategies Data Source: Implementation plan and documentation of milestones Process Milestone 4 Estimated Incentive Payment: $205,212	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED utilization for patients using/needing specialty care services by 10% Baseline: 7,198 visits to ED from identified medicine clinics Goal: Reduce # visits to ED by 10% Data Source: EHR, internal data systems Outcome Improvement Target 1 Estimated Incentive Payment*:* $658,586	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED utilization for patients using/needing specialty care services by 15% from baseline Goal: Reduce # visits to ED by 15% from baseline Data Source: EHR, internal data systems Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,574,879
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $354,078	**Year 3 Estimated Outcome Amount:** $410,423	**Year 4 Estimated Outcome Amount: $658,586**	**Year 5 Estimated Outcome Amount:** $1,574,879
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,997,966			

Title of Outcome Measure (Improvement Target): IT-1.2 – Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)

Unique RHP outcome identification number: 127295703.3.15

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-1.2 - Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)

Defined as the percentage of established patients 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Numerator: Established patients from the denominator with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year

Inclusions: Established patients must meet 1 of the following criteria to be compliant:

- Code for a lab panel test during measurement year
- Code for serum potassium & code for serum creatinine during measurement year
- Code for serum potassium & code for blood urea nitrogen during measurement year

Note: Tests don't need to occur on same service date, only within measurement year

Denominator: Established patients 18 years of age or older as of December 31 of the measurement year on persistent angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) – defined as patients who received at least 180 treatment days of ambulatory medication during measurement year.

Inclusions: Members 18 years of age and older as of December 31 of the measurement year on persistent angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) – defined as members who received at least 180 treatment days of ambulatory medication during the measure year. Note:

- Patients must have been continuously enrolled during the measurement year.

- Allowable gap: No more than one gap in enrollment of up to 45 days during each year of continuous enrollments (commercial, Medicare). To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the patient may not have more than a 1-month gap in coverage.

- Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days).

- Refer to Table CDC-L in the original measure documentation to identify ACE inhibitors and ARBs. Patients may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days supply for those medication count toward the total 180 treatment days (i.e., a patient who received 90 days of ACE inhibitors and 90 days of ARBs meet the denominator definition for measure).

Exclusions: Exclude patients who had an inpatient (acute or non-acute) claim/encounter during the measurement year.

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 a baseline rate among established patients

Outcome Improvement Targets:

- DY4:
    - IT-1.2: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – ACE inhibitors or angiotensin receptor blockers (ARBs)
        - Improvement Target – CHF: 85%
        - Improvement Target – Diabetes: 85%
- DY5:
    - IT-1.2: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – ACE inhibitors or angiotensin receptor blockers (ARBs)
        - Improvement Target – CHF: 88%
        - Improvement Target – Diabetes: 88%

Rationale

Hypertension and diabetes are two of Parkland's most common diagnoses, resulting in a significant number of patients on chronic medications needing to be monitored to decrease risk of adverse drug events from long-term medication use or misuse of medications. Persistent use of ACE Inhibitors or ARBs warrants monitoring and follow-up by the medical home to assess for side-effects, particularly loss of kidney function, and adjust drug dosage/therapeutic decisions accordingly.[559] The costs of annual monitoring are then offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications[560].

Process milestones were chosen to in order to insure processes are in place to successfully monitor progress. ~~to insure Parkland's primary care clinics meet the 2011 Medical Home Criteria for certification.~~ Parkland intends to promote care management and the use of the medical home model and chronic care model in all care settings and while Parkland's community-oriented primary care clinics (COPCs) are certified as medical homes under the 2008 guidelines, a readiness assessment and plan must be implemented to meet the updated 2011 guidelines. All Parkland initiatives are focused on balancing the care continuum through increased access and empaneling patients to medical home care teams and also implementing a chronic care model throughout the health system. The focus is to better serve those patients who have chronic conditions and need care teams to assist them to meet their health goals. Elements of the care model through the medical home include monitoring medications, insuring screenings and preventive services are provided and maintaining adequate communication between the care teams and the patient. This outcome is a component of the care model Parkland is implementing across the system.

Related Category 1 and/or 2 Projects

- 127295703.2.1: Expand Medical Home model – community practices

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

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[559] Jessup, M., et al., *2009 focused update: ACCF/AHA guidelines for the diagnosis and management of heart failure in adults: a report of American College of Cardiology Foundation/American Heart Association Taks Force on Practice Guidelines: developed in collaboration with the International Society for Heart and Lung Transplantation.* 2009. 119(14): p. 1977-2016.

[560] Briggs, A., et al., *Cost effectiveness of perindopril in reducing cardiovasular events in patients with stable coronary artery disease using data from the EUROPA study.* Heart, 2007. **93**: p. 1081-1086.

127295703.3.15	*3.IT.1.2*	*Annual monitoring for patients on persistent medications – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.2.1 – Enhance/Expand Medical Home Model – COPCs*		
Starting Point/Baseline:		*Diabetes: 82.5% (2,282/2,766 patients); CHF: 83.7% (605/703 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]: Project Planning – engage stakeholders, identify capacity and needed resources, determine timelines and document implementation plans Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment (max amount): $300,473		**Process Milestone 2** [P-2]: Establish baseline rate Goal: Determine baseline Data Source: Evidence-based literature, other documentation Process Milestone 2 Estimated Incentive Payment: $348,287	**Outcome Improvement Target 1** [IT-1.2] Annual monitoring for patients on persistent medications – ACE inhibitors or angiotensin receptor blockers (ARBs) Improvement Target: 85% of eligible patients monitored during the year Baseline: Diabetes was 82.5% (2,282/2,766); CHF was 83.7% (605/703 Goal: 85% monitored Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 1 Estimated Incentive Payment*:* $558,880	**Outcome Improvement Target 2** [IT-1.2] Annual monitoring for patients on persistent medications – ACE inhibitors or angiotensin receptor blockers (ARBs) Improvement Target: 88% of eligible patients monitored during the year Goal: 88% monitored Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,336,451
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $300,473		**Year 3 Estimated Outcome Amount:** $348,287	**Year 4 Estimated Outcome Amount:** $558,880	**Year 5 Estimated Outcome Amount**: $1,336,451
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $2,544,091				

Title of Outcome Measure (Improvement Target): IT-1.12 – Diabetes Care: Retinal Eye Exam

Unique RHP outcome identification number: 127295703.3.16

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-1.12 - Diabetes Care: Retinal Eye Exam (NQF 0055) (Non-standalone Measure)

Numerator: An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

a) A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, or

b) A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year

Denominator: Members 18 to 75 year of age as of December 31 of the measurement year with diabetes (type 1 or type 2)

Process Milestones:

- DY2:
    - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
    - P-2: Establish a baseline rate among established patients

Outcome Improvement Targets:

- DY4:
    - IT-1.12: Increase number of COPC patients with diabetes had a retinal exam in the recommended time-frame. Improvement Target: 2,500
- DY5:
    - IT-1.12: Increase number of COPC patients with diabetes had a retinal exam in the recommended time-frame. Improvement Target: 3,000

Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 25.8 million Americans have diabetes, of which about 7 million are undiagnosed[561]. In addition, diabetes was the seventh leading cause of death in Americans of all ages in 2009, and the fifth leading cause of death among the "young old," ages 65-79[562]. Diabetic retinopathy, one of the leading causes of blindness in adults, can be treated if detected and addressed in the early stages[563].

Process milestones were chosen due to promote chronic disease management and the use of the chronic disease management mode in the primary care clinics. In DY2, we will complete the process currently under way of installing retinal scan cameras and training clinicians in their use. This will include using existing relationship between Parkland optometrists and the ophthalmology department of our clinical partner, University of Texas Southwestern Medical School. Retinal scan results will be entered into the patient's EHR record.

In DY3, we will use current data to establish a baseline from which to set goals for DY3, DY4 and DY5. Once the retinal scan cameras and the necessary clinical teams are in place and trained, we will begin routine use of the retinal cameras for diabetic eye exams, including putting retinal scan compliance in the diabetic registry, at one pilot location. At the end of the year we will compare our rate of scans to our goal, study successes and failures of process and information technology and adjust the system. In DY4 and DY5, we will roll out the system at all sites to insure identified diabetic patients have retinal eye exams. We will also study successes and failures for any potential improvements.

Related Category 1 and/or 2 Projects

- 127295703.2.1: Expand Medical Home model – community practices

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

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[561] US Department of Health and Human Services, C.f.D.C.a.P. National Diabetes Fact Sheet 2011. 2011; Available from: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

[562] National Vital Statistics System, C.N., Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 5-year age group, by race/ sex: US, 1999-2009, C.f.D.C.a.P. US Department of Health and Human Services, Editor 2009.

[563] American Optometric Association. Diabetes is the leading cause of blindness among most adults. 2012 [cited 2012 October 19]; Available from: http://www.aoa.org/x6814.xml.

127295703.3.16	*3.IT-1.12*	*Diabetes – Retinal Eye Exam*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.2.1 – Enhance/Expand Medical Home model - COPCs*		
Starting Point/Baseline:		*0 in FY2011*		
Year 2 (10/1/2012 – 9/30/2013)		**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 Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment: $300,473		**Process Milestone 2** [P-2]: Establish baseline rate Goal: Determine baseline Data Source: Evidence-based literature, national benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $348,287	**Outcome Improvement Target 1** [IT-1.12] Increase number of COPC established diabetic patients who have retinal exam in recommended time frame Improvement Target: 2,500 patients to receive retinal eye exams Baseline: 0 in FY11 Goal: 2,500 patients to have retinal eye exam Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 1 Estimated Incentive Payment: $558,879	**Outcome Improvement Target 2** [IT-1.12] Increase percentage of COPC established diabetic patients who have retinal exam in recommended time frame Improvement Target: 3,000 patients to receive retinal eye exam Goal: 3,000 patients to have retinal eye exam Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 2 Estimated Incentive Payment: $1,336,450
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $300,473		**Year 3 Estimated Outcome Amount:** $348,287	**Year 4 Estimated Outcome Amount:** $558,879	**Year 5 Estimated Outcome Amount:** $1,336,450
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,544,089				

Title of Outcome Measure (Improvement Target): IT-1.20 – Other: Preventive services for children and adolescents (ICSI/AHRQ Measure) – Recommended Adolescent Immunizations

Unique RHP outcome identification number: 127295703.3.17

Performing Provider Name/ TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-12.6: Other Outcome Improvement Target (ICSI/AHRQ Measure): Preventive services for children and adolescents: percentage of patients who by age 13 years were up-to-date with recommended adolescent immunizations: 1) one MCV4 – meningococcal, 2) one Tdap – tetanus, diphtheria toxoids and acellular pertussis vaccine within the last year (NQF Measure)

Numerator: Number of established patients ages 13-17 who received both vaccine doses

Denominator: Number of established patients ages 13-17

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 a baseline rate among established patients

Outcome Improvement Targets:

- DY4:
    - IT-12.6: Increase percentage of established pediatric patients age 13 and older who have had the recommended vaccine combination within the past year. Improvement Target: 75% compliance
        - Numerator: Established patients ages 13-17 who have received all four vaccine doses, including receiving the influenza vaccine within past year
        - Denominator: Established patients ages 13-17.

- DY5:
    - IT-12.6: Increase percentage of established pediatric patients age 13 and older who have had the recommended vaccine combination within the past year. Improvement Target: 80% compliance
        - Numerator: Established patients ages 13-17 who have received all four vaccine doses, including receiving the influenza vaccine within past year
        - Denominator: Established patients ages 13-17.

Rationale

The Institute for Clinical Systems Improvement has made these four vaccines part of their Level I recommendations for this age group. The priority aim addressed by this measure is to increase the rate of pediatric patients up-to-date with Level I preventive services, the highest priority of clinical services[564]. The following vaccines are recommended by the American Academy of Pediatrics, the American Academy of Family Medicine, the CDC and AHRQ.

- Tdap vaccine which protects against tetanus, diphtheria and pertussis
- Meningococcal conjugate vaccine, which prevents meningococcal disease (10-14% of invasive meningococcal infections are fatal, and another 11-19% result in long-term disability such as deafness, brain damage, or an amputated arm or leg; in the U.S., the prevalence of invasive meningococcal disease peaks in infants, with a second peak in adolescents

Parkland sees approximately 5,500, thirteen-year-old patients in its COPC health centers annually. Improvement in the immunization rates for this population will insure the health of our community and in decreasing illness and disability caused by these vaccine preventable conditions.

Process milestones were chosen due to insure capacity and needed resources are addressed to insure prevention measures can be taken. Improvement milestones will measure success of the process milestones.

Related Category 1 and/or 2 Projects

- 127295703.2.1: Expand Medical Home model – community practices

[564] *Wilkinson, J., Health care guideline: preventive services children and adolescents, in Level I Services, C. Bass, Editor 2012, Institute for Healthcare Improvement.*

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

127295703.3.17	*3.IT-1.20*	*Other (ICSI/AHRQ Measure)-Preventive Services for Children and Adolescents: Percentage of patients who by age 13 years were up-to-date with recommended adolescent immunizations: 1) one MCV 2) one Tdap and acellular pertussis*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.2.1 – Enhance/Expand Medical Home Model – COPCs*		
Starting Point/Baseline:		*66% Compliance (1,617/2,456 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $118,106		**Process Milestone 2** [P-3]: Establish baseline rate Goal: Determine baseline Data Source: Peer-reviewed literature, national benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $136,901	**Outcome Improvement Target 1** [IT-12.6] Increase percentage of established pediatric patients age 13 and older who have recommended vaccine combination Improvement Target: 75% of patients age 13 and older who receive vaccine combination Baseline: 66% compliance (1,617/2,456 patients) Goal: 75% compliance Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 1 Estimated Incentive Payment*:* $219,677	**Outcome Improvement Target 2** [IT-12.6] Increase percentage of established pediatric patients age 13 and older who have recommended vaccine combination Improvement Target: 80% of patients age 13 and older who receive vaccine combination Goal: 80% compliance Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 2 Estimated Incentive Payment*:* $525,316
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $118,106		**Year 3 Estimated Outcome Amount:** $136,901	**Year 4 Estimated Outcome Amount:** $219,677	**Year 5 Estimated Outcome Amount:** $525,316
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,000,000				

Title of Outcome Measure (Improvement Target): IT-1.2 – Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)

Unique RHP outcome identification number: 127295703.3.22

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-1.2 - Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)

Defined as the percentage of established patients 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Numerator: Established patients from the denominator with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Inclusions: Established patients must meet one of the following criteria to be compliant:

- Code for a lab panel test during measurement year
- Code for serum potassium and code for serum creatinine during measurement year
- Code for serum potassium & code for blood urea nitrogen during measurement year

Note: Tests don't need to occur on same service date, only within measurement year

Denominator: Established patients 18 years of age or older as of December 31 of the measurement year on persistent angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) – defined as patients who received at least 180 treatment days of ambulatory medication during measurement year.

Inclusions: Members 18 years of age and older as of December 31 of the measurement year on persistent angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) – defined as members who received at least 180 treatment days of ambulatory medication during the measure year. Note:

- Patients must have been continuously enrolled during the measurement year.

- Allowable gap: No more than one gap in enrollment of up to 45 days during each year of continuous enrollments (commercial, Medicare). To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the patient may not have more than a 1-month gap in coverage.

- Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days).

- Refer to Table CDC-L in the original measure documentation to identify ACE inhibitors and ARBs. Patients may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days supply for those medication count toward the total 180 treatment days (ie a patient who received 90 days of ACE inhibitors and 90 days of ARBs meet the denominator definition for this measure).

Exclusions: Exclude patients who had an inpatient (acute or non-acute) claim/encounter during the measurement year.

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 a baseline rate among established patients

Outcome Improvement Targets:

- DY4:
    - IT-1.2: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – ACE inhibitors or angiotensin receptor blockers (ARBs)
        - Improvement Target – CHF: 85%
        - Improvement Target – Diabetes: 85%
- DY5:
    - IT-1.2: Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – ACE inhibitors or angiotensin receptor blockers (ARBs)
        - Improvement Target – CHF: 88%
        - Improvement Target – Diabetes: 88%

Rationale

Hypertension and diabetes are two of Parkland's most common diagnoses, resulting in a significant number of patients on chronic medications needing to be monitored to decrease risk of adverse drug events from long-term medication use or misuse of medications. Persistent use of ACE Inhibitors or ARBs warrants monitoring and follow-up by the medical home to assess for side-effects, particularly loss of kidney function, and adjust drug dosage/therapeutic decisions accordingly.[565]

The costs of annual monitoring are then offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications[566].

Process milestones were chosen to in order to insure processes are in place to successfully monitor progress. Parkland intends to promote care management and the use of the medical home model and chronic care model in all care settings and while Parkland's community-oriented primary care clinics (COPCs) are certified as medical homes under the 2008 guidelines, a readiness assessment and plan must be implemented to meet the updated 2011 guidelines. All Parkland initiatives are focused on balancing the care continuum through increased access and empaneling patients to medical home care teams and also implementing a chronic care model throughout the health system. The focus is to better serve those patients who have chronic conditions and need care teams to assist them to meet their health goals. Elements of the care model through the medical home include monitoring medications, insuring screenings and preventive services are provided and maintaining adequate communication between the care teams and the patient. This outcome is a component of the care model Parkland is implementing across the system.

Related Category 1 and/or 2 Projects

- 127295703.2.4: Expand Chronic Care Management Model

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and

[565] Jessup, M., et al., *2009 focused update: ACCF/AHA guidelines for diagnosis and management of heart failure in adults: Report of American College of Cardiology Foundation/American Heart Association Taks Force on Practice Guidelines: developed in collaboration with the International Society for Heart and Lung Transplantation.* 2009. 119(14): p 1977-2016.

[566] Briggs, A., et al., *Cost effectiveness of perindopril in reducing cardiovasular events in patients with stable coronary artery disease using data from the EUROPA study.* Heart, 2007. 93: p. 1081-1086.

2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

127295703.3.22	*3.IT.1.2*	*Annual monitoring for patients on persistent medications – angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.2.4 – Expand Chronic Care Management Model*		
Starting Point/Baseline:		*Diabetes: 82.5% (2,282/2,766 patients); CHF: 83.7% (605/703 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment (max amount): $315,947		**Process Milestone 2** [P-2]: Establish baseline rate Use pilot test data, peer reviewed literature and consensus of adult health physicians to establish goals for DY3, DY4 and DY5 Goal: Determine baseline Data Source: Peer reviewed literature, benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $366,224	**Outcome Improvement Target 1** [IT-1.2] Annual monitoring for patients on persistent medications: ACE inhibitors or ARBs Improvement Target: 85% of eligible patients monitored during the year Baseline: Diabetes is 82.5% (2,282/2,766 patients); CHF is 83.7% Goal: 85% monitored Data Source: EHR, registry, report Outcome Improvement Target 1 Estimated Incentive Payment: $587,661	**Outcome Improvement Target 2** [IT-1.2] Annual monitoring for patients on persistent medications: ACE inhibitors or ARBs Improvement Target: 88% of eligible patients monitored during the year Goal: 88% monitored Data Source: EHR, registry, report Outcome Improvement Target 2 Estimated Incentive Payment: $1,405,277
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $315,947		**Year 3 Estimated Outcome Amount:** $366,224	**Year 4 Estimated Outcome Amount:** $587,661	**Year 5 Estimated Outcome Amount:** $1,405,277
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,675,109				

Title of Outcome Measure (Improvement Target): IT-1.12 – Diabetes Care: Retinal Eye Exam

Unique RHP outcome identification number: 127295703.3.23

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-1.12 - Diabetes Care: Retinal Eye Exam (NQF 0055) (Non-standalone Measure)

Numerator: An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

a) A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, or

b) A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year

Denominator: Members 18 to 75 year of age as of December 31 of the measurement year with diabetes (type 1 or type 2)

Process Milestones:

- DY2
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2: Establish a baseline rate among established patients

Outcome Improvement Targets:

- DY4:
  - IT-1.12: Increase number of COPC patients with diabetes had a retinal exam in the recommended time-frame. Improvement Target: 2,500
- DY 5:
  - IT-1.12: Increase number of COPC patients with diabetes had a retinal exam in the recommended time-frame. Improvement Target: 3,000

Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 25.8 million Americans have diabetes, of which about 7 million are undiagnosed[567]. In addition, diabetes was the seventh leading cause of death in Americans of all ages in 2009, and the fifth leading cause of death among the "young old," ages 65-79[568]. Diabetic retinopathy, one of the leading causes of blindness in adults, can be treated if detected and addressed in the early stages[569].

Process milestones were chosen due to promote chronic disease management and the use of the chronic disease management mode in the primary care clinics. In DY2, we will complete the process currently under way of installing retinal scan cameras and training clinicians in their use. This will include using existing relationship between Parkland optometrists and the ophthalmology department of our clinical partner, University of Texas Southwestern Medical School. Retinal scan results will be entered into the patient's EHR record.

In DY3, we will use current data to establish a baseline from which to set goals for DY3, DY4 and DY5. Once the retinal scan cameras and the necessary clinical teams are in place and trained, we will begin routine use of the retinal cameras for diabetic eye exams, including putting retinal scan compliance in the diabetic registry, at one pilot location. At the end of the year we will compare our rate of scans to our goal, study successes and failures of process and information technology and adjust the system. In DY4 and DY5, we will roll out the system at all sites to insure identified diabetic patients have retinal eye exams. We will also study successes and failures for any potential improvements.

Related Category 1 and/or 2 Projects

- 127295703.2.4: Expand Chronic Care Management model

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

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[567] US Department of Health and Human Services, C.f.D.C.a.P. National Diabetes Fact Sheet 2011. 2011; Available from: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

[568] National Vital Statistics System, C.N., Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 5-year age group, by race/ sex: US, 1999-2009, C.f.D.C.a.P. US Department of Health and Human Services, Editor 2009.

[569] American Optometric Association. Diabetes is the leading cause of blindness among most adults. 2012 [cited 2012 October 19]; Available from: http://www.aoa.org/x6814.xml.

127295703.3.23	*3.IT-1.12*	*Diabetes – Retinal Eye Exam*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.2.4 – Expand Chronic Care Management Model*		
Starting Point/Baseline:		*0 in FY2011*		
Year 2 (10/1/2012 – 9/30/2013)		**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 Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment: $315,947		**Process Milestone 2** [P-2]: Establish baseline rate Goal: Determine baseline Data Source: Peer-reviewed literature, national benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $366,224	**Outcome Improvement Target 1** [IT-1.12] Increase number of COPC established diabetic patients who have retinal exam in the recommended time frame Improvement Target: 2,500 patients to have retinal eye exams Baseline: 0 in FY2011 Goal: 2,500 diabetic patients to receive eye exam Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 1 Estimated Incentive Payment*:* $587,661	**Outcome Improvement Target 2** [IT-1.12] Increase percentage of COPC established diabetic patients who have retinal exam in the recommended time frame Improvement Target: 3,000 patients to have retinal eye exams Goal: 3,000 diabetic patients to receive eye exam Data Source: EHR, registry, claims, administrative data Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,405,277
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $315,947		**Year 3 Estimated Outcome Amount:** $366,224	**Year 4 Estimated Outcome Amount:** $587,661	**Year 5 Estimated Outcome Amount:** $1,405,277
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $2,675,109				

Title of Outcome Measure (Improvement Target): IT-3.3 – Diabetes 30-day Readmission Rate

Unique RHP outcome identification number(s): 127295703.3.24

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-3.3 – Diabetes 30-day Readmission Rate (Standalone Measure)

Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

Process Milestones

- DY2:
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, document implementation plans
  - P-2: Establish baseline rates
- DY3:
  - P-4: Conduct PDSA cycle to improve data collection and intervention activities
  - P-5: Disseminate findings, including best practices and lessons learned

Outcome Improvement Targets for each year

- DY4:
  - IT-3.2: Diabetes 30-day Readmission Rate. Improvement target: 9.0%
- DY5:
  - IT-3.2: Diabetes 30-day Readmission Rate. Improvement target: 8.7%

Rationale

As the Planning Protocol Category 3 restates, the relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay.[570]

Parkland intends to conduct performance improvement projects using PI methodologies to improve readmission rates such as All Cause, AMI and Diabetes (CHF readmissions have already been improved significantly). One of the initiatives to improve readmissions is to implement an effective discharge planning process which is another of Parkland's key objectives.

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 25.8 million Americans have diabetes, and about 7 million of these cases are undiagnosed[571]. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes was the seventh leading cause of death in Americans of all ages in 2009, and the fifth leading cause of death among the "young old," ages 65-79[572].

Parkland has done some preliminary work on identifying those patients with chronic diseases/conditions, specifically diabetes, who may be bouncing around the health care system without any focused effort in directed and effective delivery of health care. Work has begun to develop the appropriate clinical protocols and chronic care management model to care for patients with conditions such as diabetes. Several projects are focused on diabetes outcomes to insure that efforts across the continuum are focused. It is important to insure that patients are identified and followed throughout the care process to insure effective care management.

To appropriately understand the causes for readmissions, a plan must be developed, which will be addressed in DY2 with findings disseminated in DY3. In DY2 we will also establish the baseline and in DY3, we will conduct a PDSA cycle. Improvement targets will determine success of interventions.

Related Category 1 and/or 2 Projects

- 127295703.2.4: Expand Chronic Care Model

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and

[570] Goldfield N, McCullough E, Hughes, Tang A, Eastman B, Rawlins L, Averill R. 2008. "Identifying Potentially Preventable Readmissions." *Health Care Financing Review*. 30:1; pp75 -91.

[571] US Department of Health and Human Services, C.f.D.C.a.P. *National Diabetes Fact Sheet 2011*. 2011; Available from: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

[572] National Vital Statistics System, C.N., *Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 5-year age group, by race and sex: United States, 1999-2009*, C.f.D.C.a.P. US Dept of Health and Human Services, Editor 2009.

2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

1272957033.24	*3.IT-3.3*	*Diabetes 30-Day Readmission Rate*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:	*127295703.2.4 – Expand Chronic Care Management Model*		
Starting Point/Baseline:	*9.2% (117/1,272 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation of plan Goal: Develop plan Data Source: Plan, other documentation Process Milestone 1 Estimated Incentive Payment (max amount): $157,973 **Process Milestone 2** [P-2]: Establish baseline rates Goal: Determine baseline Data Source: Peer-reviewed literature, national benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment (max amount): $157,974	**Process Milestone 3** [P-4] Conduct PDSA cycle to improve data collection and intervention activities Goal: Initiate PDSA Data Source: Documentation Process Milestone 3 Estimated Incentive Payment : $183,111 **Process Milestone 4** [P-5] Disseminate findings, including best practices and lessons learned Goal: Summarize findings Data Source: Plan, Report Process Milestone 4 Estimated Incentive Payment (max amount): $183,112	**Outcome Improvement Target 1** [IT-3.3]: Diabetes 30-day Readmissions Rate Improvement Target: Improve diabetes 30-day readmissions rate to 9.0% Baseline: 9.2% in FY2012 (117/1,272 patients) Goal: 9.0% readmissions rate Data Source: EHR, Claims, Benchmark Report, Documentation Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $587,662	**Outcome Improvement Target 2** [IT-3.3]: Diabetes 30-day Readmissions Rate Improvement Target: Improve diabetes 30-day readmissions rate to 8.7% Goal: 8.7% readmissions rate Data Source: EHR, Claims, Benchmark Report, Documentation Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $1,405,277
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $315,947	**Year 3 Estimated Outcome Amount:** $366,223	**Year 4 Estimated Outcome Amount:** $587,662	**Year 5 Estimated Outcome Amount:** $1,405,277

1272957033.24	*3.IT-3.3*	*Diabetes 30-Day Readmission Rate*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:	*127295703.2.4 – Expand Chronic Care Management Model*			
Starting Point/Baseline:	*9.2% (117/1,272 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)**	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,675,109				

Title of Outcome Measure (Improvement Target): IT-5.1 – Improved Cost Savings
(demonstrate cost savings in care delivery)

Unique RHP outcome identification number(s): 127295703.3.25

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-5.1: Improved Cost savings (Standalone for Project Option 5)

Cost Benefit Analysis will be used to analyze the direct and indirect costs and benefits of implementing a new program at Parkland Health & Hospital System. The measure will be the reduction in costs due to implementing the program or the improvement in cost savings.

Process Milestones

- DY2:
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, document implementation plans
  - P-7: Conduct cost benefit analysis
- DY3:
  - P-7: Determine plan of action with time line/milestones
  - P-2: Establish baseline

Outcome Improvement Targets for each year

- DY4:
  - IT-5.1: Improved Cost savings: Using the Cost Minimization analysis, achieve a system-wide reduction in cost associated with the pilot project of at least .5% (equates to approximately $5 million impact on direct medical costs)
- DY5:
  - IT-5.1: Improved Cost savings: Using the Cost Minimization analysis, sustain a system-wide reduction in cost associated with the pilot project of at least .5% (equates to approximately $5 million impact on direct medical costs)

Rationale

Cost savings can be demonstrated in a health care environment by assigning a monetary value to all aspects of a health care system. The monetary value depends on the direct or indirect cost of health care. Cost benefit analysis is used to summarize the cost and benefits of programs in a health care system to establish if it is effective in providing quality care delivery

to the patient. The costs and benefits are usually monitored over time and need to be adjusted to the same time frame for the analysis. This type of analysis has been widely applied within the health care industry. One example is the potential savings of effectively implementing an electronic medical record (EMR) system.[573] The cost of a project is important to understand the risk of continuing to support a program in a health care system. The cost benefit analysis would identify the opportunities to reduce the cost of care. A reduction in the cost of care would increase efficiency at Parkland and allow more resources to be used to benefit the patient population.

Related Category 1 and/or 2 Projects

- 127295703.2.5: Cost Effectiveness of Post-Acute Care Alternatives

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

[573] Richard Hillestad, James Bigelow, Anthony Bower, Federico Girosi, Robin Meili, Richard Scoville and Roger Taylor, "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, And Costs." *Health Affairs*, 24, no.5 (2005):1103-1117.

127295703.3.25	*3.IT-5.1*	*Improved Cost Savings*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:	*127295703.2.5 – Cost Effectiveness of Post-Acute Care Alternatives*		
Starting Point/Baseline:	*To be developed in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project or plan documentation Process Milestone 1 Estimated Incentive Payment (max amount): $446,684	**Process Milestone 2** [P-7]: Conduct cost benefit analysis Data Source: Analysis Process Milestone 2 Estimated Incentive Payment (max amount): $172,588 **Process Milestone 3** [P-7]: Determine plan of action with timeline/ milestones for implementation Data Source: Plan documentation Process Milestone 3 Estimated Incentive Payment (max amount): $172,588 **Process Milestone 4** [P-2]: Establish baseline cost for post-acute Data Source: Baseline analysis Process Milestone 4 Estimated Incentive Payment (max amount): $172,589	**Outcome Improvement Target 1** [IT-5.1] Improved Cost savings: demonstrate cost savings in care delivery Improvement Target: Using the Cost Minimization analysis, achieve a system-wide reduction in cost associated with the pilot project of at least .5% (equates to approximately $5 million impact on direct medical costs)baseline established in DY3 Baseline: TBD in DY 3 Data Source: Cost Minimization analysis Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $830,832	**Outcome Improvement Target 2** [IT-5.1] Improved Cost savings: demonstrate cost savings in care delivery Improvement Target: Using the Cost Minimization analysis, sustain a system-wide reduction in cost associated with the pilot project of at least .5% (equates to approximately $5 million impact on direct medical costs) baseline established in DY3 Baseline: TBD in DY 3 Data Source: Cost Minimization analysis Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $1,986,771
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $446,684	**Year 3 Estimated Outcome Amount:** $517,765	**Year 4 Estimated Outcome Amount:** $830,832	**Year 5 Estimated Outcome Amount:** $1,986,771
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $3,782,052			

Title of Outcome Measure (Improvement Target): IT-5.2 – Per Episode Cost of Care

Unique RHP outcome identification number(s): 127295703.3.26

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-5.2: Per Episode Cost of Care (Standalone for Project Option 5)

Cost Benefit Analysis will be used to analyze the direct and indirect costs and benefits of implementing a new program at Parkland Health & Hospital System. The measure will be the reduction in costs due to implementing the program or the improvement in cost savings.

Process Milestones

- DY2:
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, document implementation plans
  - P-7: Conduct cost benefit analysis
- DY3:
  - P-7: Determine plan of action with timeline/milestones
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year

- DY4:
  - IT-5.1:Improved Cost savings: Evaluate the pre- and post- cost per episode of care the target population in the pilot and achieve cost saving of at least 10%
- DY5:
  - IT-5.1:Improved Cost savings: Evaluate the pre- and post- cost per episode of care the target population in the pilot and sustain cost saving of at least 10%
  - Improvement target: Reduction of 10% from baseline established in DY3

Rationale

Cost savings can be demonstrated in a health care environment by assigning a monetary value to all aspects of a health care system. The monetary value depends on the direct or indirect cost of health care. Cost benefit analysis is used to summarize the cost and benefits of programs in a health care system to establish if it is effective in providing quality care delivery to the patient. The costs and benefits are usually monitored over time and need to be adjusted

to the same time frame for the analysis. This type of analysis has been widely applied within the health care industry. One example is the potential savings of effectively implementing an electronic medical record (EMR) system.[574] The cost of a project is important to understand the risk of continuing to support a program in a health care system. The cost benefit analysis would identify the opportunities to reduce the cost of care. A reduction in the cost of care would increase efficiency at Parkland and allow more resources to be used to benefit the patient population.

Related Category 1 and/or 2 Projects

- 127295703.2.5: Cost Effectiveness of Post-Acute Care Alternatives

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

[574] Richard Hillestad, James Bigelow, Anthony Bower, Federico Girosi, Robin Meili, Richard Scoville and Roger Taylor, "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, And Costs." *Health Affairs*, 24, no.5 (2005):1103-1117.

127295703.3.26	*3.IT-5.2*	*Per Episode Cost of Care*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:		*127295703.2.5 – Cost Effectiveness of Post-Acute Care Alternatives*	
Starting Point/Baseline:		*To be developed in DY3*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project or plan documentation Process Milestone 1 Estimated Incentive Payment (max amount): $223,341 **Process Milestone 2** [P-7]: Conduct cost benefit analysis Data Source: Analysis Process Milestone 2 Estimated Incentive Payment (max amount): $223,342		**Process Milestone 3** [P-7]: Determine plan of action with timeline/milestones for implementation Data Source: Plan documentation Process Milestone 3 Estimated Incentive Payment (max amount): $258,882 **Process Milestone 4** [P-2]: Establish baseline cost for post-acute Data Source: Baseline analysis Process Milestone 4 Estimated Incentive Payment (max amount): $258,882	**Outcome Improvement Target 1** [IT-5.1] Improved Cost savings: demonstrate cost savings in care delivery Improvement Target: Achieve reduction of 10% from baseline established in DY3 Numerator: Total annual cost for patients in pilot Denominator: Number of episodes per year Data source: EHR, Parkland cost accounting data Baseline: TBD in DY 3 Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $830,831	**Outcome Improvement Target 2** [IT-5.1] Improved Cost savings: demonstrate cost savings in care delivery Improvement Target: : Achieve reduction of 10% from baseline established in DY3 Numerator: Total annual cost for patients in pilot Denominator: Number of episodes per year Data source: EHR, Parkland cost accounting data Baseline: TBD in DY 3 Data Source: Cost Minimization analysis Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $1,986,771
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $446,683		**Year 3 Estimated Outcome Amount:** $517,764	**Year 4 Estimated Outcome Amount:** $830,831	**Year 5 Estimated Outcome Amount:** $1,986,771
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $3,782,049				

Title of Outcome Measure (Improvement Target): IT-4.2 – Central Line-Associated Bloodstream Infection (CLABSI) Rate

Unique RHP outcome identification number(s): 127295703.3.27

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-4.2 – Central Line-Associated Bloodstream Infection (CLABSI) Rate (Standalone Measure)

Numerator: Number of cases of CLABSI as designated by IQR criteria

Data Source: Claims, EHR, IQR/NHSN Data

Process Milestones

- DY2:
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, document implementation plans
  - P-2: Establish baseline rates
- DY3:
  - P-5: Disseminate findings, including best practices and lessons learned
  - P-7: Implement strategies

Outcome Improvement Targets for each year

- DY4:
  - IT-4.2: Central Line Associated Bloodstream Infection Rate. Improvement Target: Reduce CLABSI rate by 25% from DY3
- DY5:
  - IT-4.2: Central Line-Associated Bloodstream Infection Rate. Improvement Target: Reduce CLABSI rate an additional 25% from DY4

Rationale

An estimated 41,000 central line-associated bloodstream infections (CLABSI) occur in U.S. hospitals each year. These infections are usually serious infections typically causing a prolongation of hospital stay and increased cost and risk of mortality. CLABSI can be prevented through proper management of the central line. These techniques are addressed in the CDC's Healthcare Infection Control Practices Advisory Committee

(CDC/HIPAC) *Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011*.
The reduction of central line-associated bloodstream infections (CLABSI) at Parkland will increase the efficiency of the hospital and the health of the patient population. The current Adult ICU Total for FY2012, from October 2011 to June 2012, is 10 CALBSI within 6916 line days that indicates a 1.4 rate per 1000 line days. The previous rate per 1000 line days in FY2011 was 2.0. A small reduction in this low rate will indicate a large improvement at Parkland.[575]

Process milestones were chosen to insure the appropriate due diligence and planning is done in order to implement appropriate protocol-driven approaches and prevention strategies. The improvement targets were chosen to insure progress of process milestones and to insure alignment with national benchmarks.

Related Category 1 or 2 Projects

- 127295703.2.6: Apply Process Improvement Methodology to Improve Quality/ Efficiency - PPCs

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

[575] Parkland Sharepoint – November 2012 http://sharepoint.pmh.org/clin/pips/ic/CLBSI/FY2012/Data%20Folder/CLABSI%20ICU%20Rate%20Workbook.pdf

127295703.3.27	*3.IT-4.2*	*Central Line-Associated Bloodstream Infection (CLABSI) Rate*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.2.6 – Apply Process Improvement Methodology to Improve Quality/Efficiency - PPCs*		
Starting Point/Baseline:		*CLABSI Rate: 2.5/1,000 days*		
Year 2 (10/1/2012 – 9/30/2013)		**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 time lines and document implementation plans Goal: Develop plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment (max amount): $118,480 **Process Milestone 2** [P-2]: Establish baseline rates Goal: Determine baseline Data Source: Baseline analysis documentation Process Milestone 2 Estimated Incentive Payment (max amount): $118,480		**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices Goal: Summarize findings Data Source: Findings Report Process Milestone 3 Estimated Incentive Payment (max amount): $137,334 **Process Milestone 4** [P-7] Implement strategies Goal: Implementation of plan Data Source: Plan milestones documentation/report Process Milestone 4 Estimated Incentive Payment (max amount): $137,334	**Outcome Improvement Target 1** [IT-4.2]: Improve CLABSI Rate Improvement Target: Improve CLABSI rate by 25% from baseline Baseline: 2.5/1,000 days Goal: Improve rate by 25% Data Source: Internal Quality Report Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $440,746	**Outcome Improvement Target 2** [IT-4.2]: Improve CLABSI Rate Improvement Target: Improve CLABSI rate by 25% from DY4 Goal: Improve rate by additional 25% from DY4 Data Source: Internal Quality Report Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $1,053,958
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $236,960		**Year 3 Estimated Outcome Amount:** $274,668	**Year 4 Estimated Outcome Amount:** $440,746	**Year 5 Estimated Outcome Amount:** $1,053,958
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,006,332				

Title of Outcome Measure (Improvement Target): IT-4.3 – Catheter- Associated Urinary Tract Infection (CAUTI) Rate

Unique RHP outcome identification number(s): 127295703.3.28

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-4.3 – Catheter-Associated Urinary Tract Infection (Standalone Measure)

Numerator: Number of cases of CAUTI as designated by IQR criteria

Process Milestones

- DY2:
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, document implementation plans
  - P-2: Establish baseline rates
- DY3:
  - P-5: Disseminate findings, including best practices and lessons learned
  - P-7: Implement strategies

Outcome Improvement Targets for each year

- DY4:
  - IT-4.2: Catheter-Associated Urinary Tract Infection. Improvement Target: Improve CAUTI rate by 25% from DY3
- DY5:
  - IT-4.2: Catheter-Associated Urinary Tract Infection. Improvement Target: Improve CAUTI rate an additional 25% from DY4

Rationale

According to the Centers for Disease Control (CDC), CAUTI infections account for more than 30% of infections reported by acute care hospitals and approximately 80% of healthcare-associated urinary tract infections (UTIs) are caused by instrumentation of the urinary tract.

CAUTIs can lead to such complications as cystitis, pyelonephritis, gram-negative bacteremia, prostatitis, epididymitis, and orchitis in males and, less commonly, endocarditis, vertebral osteomyelitis, septic arthritis, endophthalmitis, and meningitis in all patients. Complications

associated with CAUTI cause discomfort to the patient, prolonged hospital stay, and increased cost and mortality. Each year, more than 13,000 deaths are associated with UTIs.

Process milestones were chosen to insure the appropriate due diligence and planning is done in order to implement appropriate protocol-driven approaches and prevention strategies. The improvement targets were chosen to insure progress of process milestones and to insure alignment with national benchmarks.

Related Category 1 or 2 Projects

- 127295703.2.6: Apply Process Improvement Methodology to Improve Quality/ Efficiency

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

127295703.3.28	*3.IT-4.3*	*Catheter-Associated Urinary Tract Infections (CAUTI) Rate*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:	*127295703.2.6 – Apply Process Improvement Methodology to Improve Quality/Efficiency - PPCs*		
Starting Point/Baseline:	*CAUTI Rate: 5.1/1,000 days*		
Year 2 (10/1/2012 – 9/30/2013)	**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 time lines and document implementation plans Goal: Develop plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment (max amount): $118,480 **Process Milestone 2** [P-2]: Establish baseline rates Goal: Determine baseline Data Source: Baseline analysis Process Milestone 2 Estimated Incentive Payment (max amount): $118,480	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices Goal: Summarize findings Data Source: Findings Report Process Milestone 3 Estimated Incentive Payment (max amount): $137,334 **Process Milestone 4** [P-7] Implement strategies Goal: Implement strategies Data Source: Documentation of plan milestones Process Milestone 4 Estimated Incentive Payment (max amount): $137,334	**Outcome Improvement Target 1** [IT-4.3]: Improve CAUTI Rate Improvement Target: Improve CAUTI rate by 25% Baseline: 5.1/1,000 days Goal: Improve rate by 25% Data Source: Internal Quality Report Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $440,746	**Outcome Improvement Target 2** [IT-4.3]: Improve CAUTI Rate Improvement Target: Improve CAUTI rate by additional 25% from DY4 Goal: Improve rate by additional 25% from DY4 Data Source: Internal Quality Report Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $1,053,958
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $236,960	**Year 3 Estimated Outcome Amount:** $274,668	**Year 4 Estimated Outcome Amount:** $440,746	**Year 5 Estimated Outcome Amount:** $1,053,958
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,006,332			

Title of Outcome Measure (Improvement Target): IT-4.4 – Surgical Site Infection (SSI) Rate

Unique RHP outcome identification number(s): 127295703.3.29

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-4.4 – Surgical Site Infection (SSI) Rate (Standalone Measure)

Numerator: Number of cases of SSI as designated by IQR criteria

Process Milestones

- DY2:
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, document implementation plans
  - P-2: Establish baseline rates

- DY3:
  - P-5: Disseminate findings, including best practices and lessons learned
  - P-7: Implement strategies

Outcome Improvement Targets for each year

- DY4:
  - IT-4.2: Surgical Site Infection Rate. Improvement Target: Improve SSI rate by 10%

- DY5:
  - IT-4.2: Surgical Site Infection Rate. Improvement Target: Improve SSI rate an additional 10% from DY4

Rationale

According to the CDC, while advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, SSIs remain a substantial cause of morbidity and mortality among hospitalized patients. In one study, among nearly 100,000 HAIs reported in one year, deaths were associated with SSIs in more than 8,000 cases.

Process milestones were chosen to insure the appropriate due diligence and planning is done in order to implement appropriate protocol-driven approaches and prevention strategies. The improvement targets were chosen to insure progress of process milestones and to insure alignment with national benchmarks.

Related Category 1 or 2 Projects

- 127295703.2.6: Apply Process Improvement Methodology to Improve Quality/ Efficiency

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

127295703.3.29	*3.IT-4.4*	*Surgical Site Infections (SSI) Rate*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.2.6 – Apply Process Improvement Methodology to Improve Quality/Efficiency - PPCs*		
Starting Point/Baseline:		*SSI Rate: 3.1/1,000 days for high risk procedures*		
Year 2 (10/1/2012 – 9/30/2013)		**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 time lines and document implementation plans Goal: Develop plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment (max amount): $118,480 **Process Milestone 2** [P-2]: Establish baseline rates Goal: Determine baseline Data Source: Baseline analysis Process Milestone 2 Estimated Incentive Payment (max amount): $118,480		**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices Goal: Summarize findings Data Source: Findings Report Process Milestone 3 Estimated Incentive Payment (max amount): $137,334 **Process Milestone 4** [P-7] Implement strategies Goal: Implement strategies Data Source: Documentation of plan milestones Process Milestone 4 Estimated Incentive Payment (max amount): $137,334	**Outcome Improvement Target 1** [IT-4.2]: Improve SSI Rate Improvement Target: Improve SSI rate by 10% Baseline: 3.1/1,000 days (high risk procedures) Goal: Improve rate by 10% Data Source: Internal Quality Report Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $440,746	**Outcome Improvement Target 2** [IT-4.2]: Improve SSI Rate Improvement Target: Improve SSI rate an additional 10% from DY4 Goal: Improve rate an additional 10% from DY4 Data Source: Internal Quality Report Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $1,053,958
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $236,960		**Year 3 Estimated Outcome Amount:** $274,668	**Year 4 Estimated Outcome Amount:** $440,746	**Year 5 Estimated Outcome Amount:** $1,053,958
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over Years 2-5):* $2,006,332				

Title of Outcome Measure (Improvement Target): IT-3.1 – All Cause 30-day Readmission Rate

Unique RHP outcome identification number(s): 127295703.3.30

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-3.1 – All Cause 30-day Readmission Rate (NQF 1789) (Standalone Measure)

> **Numerator:** The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned
>
> **Denominator:** This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or older or (2) admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups.

Process Milestones

- DY2:
  - P-1: Project Planning – engage stakeholders, identify capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline rates
- DY3:
  - P-4: Conduct PDSA cycle to improve data collection and intervention activities
  - P-5: Disseminate findings, including best practices and lessons learned

Outcome Improvement Targets for each year

- DY4:
  - IT-3.1: All Cause 30-Day Readmission Rate. Improvement target: 8.6%
- DY5:
  - IT-3.1: All Cause 30-Day Readmission Rate. Improvement target: 8.5%

Rationale

As the Planning Protocol Category 3 restates, the relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that

readmissions may result from circumstances surrounding the initial hospital stay.[576] Additionally, hospital readmissions in many cases are preventable. According to a 2009 study, nearly 20% of Medicare beneficiaries are re-hospitalized within 30 days after discharge, at an annual cost of $17 billion.[577] Causes of avoidable readmissions include hospital-acquired infections and complications; premature discharge; failure to coordinate and reconcile medications; inadequate communication among hospital personnel, patients, caregivers, and community-based clinicians; and poor planning for care transitions.

Parkland intends to conduct performance improvement projects using PI methodologies to improve readmission rates such as All Cause, AMI and Diabetes (CHF readmissions have already been improved significantly). One of the initiatives to improve readmissions is to implement an effective discharge planning process which is another of Parkland's key objectives.

Parkland has done some preliminary work on identifying those patients with chronic diseases/conditions who may be bouncing around the health care system without any focused effort in directed and effective delivery of health care. Work has begun to develop the appropriate clinical protocols and chronic care management model to care for patients with chronic conditions.

To appropriately understand the causes for readmissions, a plan must be developed, which will be addressed in DY2 with findings disseminated in DY3. In DY2 we will also establish the baseline and in DY3, we will conduct a PDSA cycle.

Improvement targets were chosen based on the timeframe allowed to develop the plan and determine processes needed to collect and report data accurately and to insure findings are reported and shared across the organization and throughout the region.

Related Category 1 or 2 Project(s)

- 127295703.2.7: Enhance Patient Navigation Program

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

[576] Goldfield N, McCullough E, Hughes, Tang A, Eastman B, Rawlins L, Averill R. 2008. "Identifying Potentially Preventable Readmissions." *Health Care Financing Review*. 30:1; pp75 -91.

[577] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N England J Med 2009; 360: 1418-1428[Erratum, N England J Med 2011;364:1582.]

127295703.3.30	*3.IT-3.1*	*All Cause 30-Day Readmission Rate*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:		*127295703.2.7 – Enhance Patient Navigation Program*	
Starting Point/Baseline:		*8.74% (2,770/31,683 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation of plan Goal: Develop plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment (max amount): $337,736 **Process Milestone 2** [P-2]: Establish baseline rates Goal: Determine baseline Data Source: Evidence-based literature, other documentation Process Milestone 2 Estimated Incentive Payment (max amount): $337,737		**Process Milestone 3** [P-4]: Conduct PDSA cycle Goal: Initiate PDSA study Data Source: PDSA cycle documentation Process Milestone 3 Estimated Incentive Payment (max amount): $391,480 **Process Milestone 4** [P-5]: Disseminate findings, including lessons learned and best practices Goal: Summarize findings and Implement strategies Data Source: Complete plan and documentation of plan milestones Process Milestone 4 Estimated Incentive Payment (max amount): $391,481	**Outcome Improvement Target 1** [IT-3.1] All Cause 30-day Readmissions Rate Improvement Target: Improve All Cause 30-day Readmission Rate to 8.6% Baseline: 8.74% (2,770/31,683 patients) Goal: 8.6% readmissions rate Data Source: EHR, Claims, Benchmark Report, Documentation Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $1,256,379	**Outcome Improvement Target 2** [IT-3.1] All Cause 30-day Readmissions Rate Improvement Target: Improve All Cause 30-day Readmission Rate to 8.5% Goal: 8.5% readmissions rate Data Source: EHR, Claims, Benchmark Report, Documentation Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $3,004,385
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $675,473		**Year 3 Estimated Outcome Amount:** $782,961	**Year 4 Estimated Outcome Amount:** $1,256,379	**Year 5 Estimated Outcome Amount:** $3,004,385
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over Years 2-5):* $5,719,198				

Title of Outcome Measure (Improvement Target): IT-13.3 – Palliative Care: Proportion of patients with more than one ED visit in the last days of life

Unique RHP outcome identification number(s): 127295703.3.33

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-13.3 - Percentage of patients with more than one ED visit in the last days of life (NQF 0211) (Standalone Measure)

Numerator: Number of patients who died from cancer and had >1 ER visit in the last 30 days of life

Denominator: Number of patients who died from cancer

Process Milestones:

- DY2:
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, document implementation plans
  - P-2: Establish baseline
- DY3:
  - P-5: Disseminate findings, including lessons learned and best practices
  - P-7: Implement strategies

Outcome Improvement Targets

- DY4:
  - IT-13.3: Percentage of patients with more than one ED visit in the last days of life. Improvement Target: 5% reduction from baseline set at end DY3
- DY5:
  - IT-13.3: Percentage of patients with more than one ED visit in the last days of life. Improvement Target: 5% reduction from baseline set at end of DY4

Rationale

Studies have shown that patients with life-threatening illness experience hospitalizations with longer than necessary lengths of stay and experience low-yield and costly medical treatments,

leading to lower patient and family satisfaction.[578] Palliative care programs have not only been proven to be more cost-effective for hospitals, but they have also proven to give patients nearing end-of-life a more patient and family-centered experience. Patients without such a program may seek care/comfort in the ED and eventually the ICU. For those experiencing end-of-life, neither of those is an acceptable choice. Initial back-of-the-envelope calculations show potential for a small 20-25 bed unit for palliative care. This waiver project will give Parkland an opportunity to pursue implementation of such a program.

Process milestones were chosen due to the lack of current and accurate data reports regarding readmissions indicators. To appropriately understand the causes for readmissions, a plan must be developed, which will be addressed in DY2-DY3. In DY3 we will establish the baseline and conduct a Plan Do Study Act (PDSA) cycle to improve the readmission rate and then disseminate findings as appropriate.

The improvement targets were chosen based on the timeframe allowed to develop the plan and determine processes needed to collect and report data accurately.

Related Category 1 and/or 2 Projects

- 127295703.2.8: Palliative Care

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

[578] R. Sean Morrison, MD; Joan D. Penrod, PhD; J. Brian Cassel, PhD; Melissa Caust-Ellenbogen, MS; Ann Litke, MFA Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers' Outcomes Group. "Cost Savings Associated With US Hospital Palliative Care Consultation Programs." ARCH INTERN MED/VOL 168 (NO. 16), SEP 8, 2008; p. 1783.

127295703.3.33	*3.IT-13.3*	*Palliative Care: Proportion of patients with more than one emergency room visit in the last days of life*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:		*127295703.2.8 – Implement Palliative Care Program*	
Starting Point/Baseline:		*(# died with ED visit in last 30 days of life: 150*	
Year 2 (10/1/2012 – 9/30/2013)		**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 activities and implementation of palliative care program Goal: Develop plan Data Source: EHR, documentation Process Milestone 1 Estimated Incentive Payment (max amount): $394,933 **Process Milestone 2** [P-2]: Establish baseline rates Goal: Determine baseline Data Source: EHR, documentation Process Milestone 2 Estimated Incentive Payment (max amount): $394,934		**Process Milestone 3** [P-5]: Disseminate findings, including best practices, lessons learned Goal: Summarize findings Data Source: Report of findings Process Milestone 3 Estimated Incentive Payment (max amount): ~~$305,187~~ $457,780 **Process Milestone 4** [P-7] Implement strategies to insure more patients who require palliative care receive consults Goal: Implement strategies Data Source: Implementation plan, documentation of milestones Process Milestone 4 Estimated Incentive Payment (max amount): $457,779	**Process Milestone 5** [P-7] Determine transition plan to provide palliative care services at new hospital (New Parkland) Goal: Transition plan for palliative care Data Source: Plan documentation Process Milestone 5 Estimated Incentive Payment (max amount): $734,577 **Outcome Improvement Target 1** [IT-13.3]: Reduce the percentage of patients with more than one ED visit in the last days of life Improvement Target: 5% reduction in target from the baseline Baseline: 150 palliative patients who died at Parkland with an ED visit within 30 days of their passing Data Source: EHR, documentation Outcome Improvement Target 1 Estimated Incentive Payment (max	**Outcome Improvement Target 2** [IT-13.3]: Reduce the percentage of patients with more than one ED visit in the last days of life Improvement Target: 5% reduction in target from the baseline Data Source: EHR, documentation Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $3,513,193

127295703.3.33	*3.IT-13.3*	*Palliative Care: Proportion of patients with more than one emergency room visit in the last days of life*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.2.8 – Implement Palliative Care Program*		
Starting Point/Baseline:		*(# died with ED visit in last 30 days of life: 150*		
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			amount): $734,576	
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $789,867		**Year 3 Estimated Outcome Amount:** $915,559	**Year 4 Estimated Outcome Amount:** $1,469,153	**Year 5 Estimated Outcome Amount**: $3,513,193
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over Years 2-5):* $6,687,772				

Title of Outcome Measure (Improvement Target): IT-3.1 – All Cause 30-day Readmission Rate

Unique RHP outcome identification number(s): 127295703.3.34

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-3.1 – All Cause 30-day Readmission Rate (NQF 1789) (Standalone Measure)

Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned

Denominator: This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or older or (2) admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups.

Process Milestones

- DY2:
  - P-1: Project Planning – engage stakeholders, identify capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline rates
- DY3:
  - P-4: Conduct PDSA cycle to improve data collection and intervention activities
  - P-5: Disseminate findings, including best practices and lessons learned

Outcome Improvement Targets for each year

- DY4:
  - IT-3.1: All Cause 30-Day Readmission Rate. Improvement target: 8.6%
- DY5:
  - IT-3.1: All Cause 30-Day Readmission Rate. Improvement target: 8.5%

Rationale

As the Planning Protocol Category 3 restates, the relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital

stay.[579] Additionally, hospital readmissions in many cases are preventable. According to a 2009 study, nearly 20% of Medicare beneficiaries are re-hospitalized within 30 days after discharge, at an annual cost of $17 billion.[580] Causes of avoidable readmissions include hospital-acquired infections and complications; premature discharge; failure to coordinate and reconcile medications; inadequate communication among hospital personnel, patients, caregivers, and community-based clinicians; and poor planning for care transitions.

To appropriately understand the causes for readmissions, a plan must be developed, which will be addressed in DY2 with findings disseminated in DY3. In DY2 we will also establish the baseline and in DY3, we will conduct a PDSA cycle. Improvement targets were chosen based on the timeframe allowed to develop the plan and determine processes needed to collect and report data accurately and to insure findings are reported and shared across the organization as well as throughout the region.

Related Category 1 or 2 Project(s)

- 127295703.2.9: Implement/Expand Care Transitions Program

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

[579] Goldfield N, McCullough E, Hughes, Tang A, Eastman B, Rawlins L, Averill R. 2008. "Identifying Potentially Preventable Readmissions." *Health Care Financing Review*. 30:1; pp75 -91.

[580] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N England J Med 2009; 360: 1418-1428[Erratum, N England J Med 2011;364:1582.]

127295703.3.34	*3.IT-3.1*	*All Cause 30-Day Readmission Rate*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:		*127295703.2.9 – Implement/Expand Care Transitions Program*	
Starting Point/Baseline:		*8.74% (2,770/31,683 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation of plan Goal: Develop plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment (max amount): $373,144 **Process Milestone 2** [P-2]: Establish baseline rates Goal: Determine baseline Data Source: Evidence-based literature, other documentation Process Milestone 2 Estimated Incentive Payment (max amount): $373,144		**Process Milestone 3** [P-4]: Conduct PDSA cycle Goal: Initiate PDSA study Data Source: PDSA cycle documentation Process Milestone 3 Estimated Incentive Payment (max amount): $432,523 **Process Milestone 4** [P-5]: Disseminate findings, including lessons learned and best practices Goal: Summarize findings and implement strategies Data Source: Complete plan and documentation of milestones Process Milestone 4 Estimated Incentive Payment (max amount): $432,523	**Outcome Improvement Target 1** [IT-3.1] All Cause 30-day Readmissions Rate Improvement Target: Improve All Cause 30-day Readmission Rate to 8.6% Baseline: 8.74% (2,770/ 31,683 patients) Goal: 8.6% readmissions rate Data Source: EHR, Claims, Benchmark Report, Documentation Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $1,388,097	**Outcome Improvement Target 2** [IT-3.1] All Cause 30-day Readmissions Rate Improvement Target: Improve All Cause 30-day Readmission Rate to 8.5% Goal: 8.5% readmissions rate Data Source: EHR, Claims, Benchmark Report, Documentation Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $3,319,361
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $746,288		**Year 3 Estimated Outcome Amount:** $865,046	**Year 4 Estimated Outcome Amount:** $1,388,097	**Year 5 Estimated Outcome Amount:** $3,319,361
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over Years 2-5):* $6,318,792				

Title of Outcome Measure (Improvement Target): IT-6.1 – Patient Satisfaction

Unique RHP outcome identification number(s): 127295703.3.37

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-6.1 Percent improvement over baseline of inpatient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)
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.

Numerator: Percent improvement in targeted patient satisfaction domain. Specific to this project: Number patients rating hospital 9 or 10 out of 10 on the "Overall Rating" HCAHPS question.

Denominator: Number of patients who were administered the survey. Specific to this project: Total number patients answering the "Overall Rating" HCAHPS question.

Process Milestones

- DY2:
    - P-1: Project Planning – Develop establish, recruit and fill a new position of Service Excellence Manager to centralize, coordinate, monitor, and lead service excellence initiatives.
- DY3:
    - P-4: Conduct performance improvement activities modeled after the Plan, Do, Check, Act (PDSA) improvement cycle process and "lessons learned" models to ensure continuous quality improvement of data collection, intervention activities, and learning materials.
    - P-5: Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement Targets for each year

- DY4:

- Three percentage point improvement in percentage of patients rating 9 or 10 out of 10 on the HCAHPS "Overall Rating" question over baseline.

- DY5:

  - Additional three percentage point improvement in percentage of patients rating 9 or 10 out of 10 on the HCAHPS "Overall Rating" question over DY4.

By the end of waiver in DY5, we will increase customer service excellence as measured by an overall six percentage point increase on the HCAHPS "Overall Rating" from the baseline reporting year of April 2011 through Mar 2012 (combined Outcome Improvement Targets 1 and 2). The six percentage point overall increase would be enough to bring Parkland scores in line with the April 2011 through Mar 2012 national average as reported by CMS preliminary estimates and would be above the VBP threshold for adjusted scores reported by CMS Final Rule in April 2011.

Rationale

"The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. While many hospitals have collected information on patient satisfaction, prior to HCAHPS there was no national standard for collecting or publicly reporting patients' perspectives of care information that would enable valid comparisons to be made across all hospitals. In order to make "apples to apples" comparisons to support consumer choice, it was necessary to introduce a standard measurement approach: the HCAHPS survey, which is also known as the CAHPS® Hospital Survey, or Hospital CAHPS. HCAHPS is a core set of questions that can be combined with a broader, customized set of hospital-specific items. HCAHPS survey items complement the data hospitals currently collect to support improvements in internal customer services and quality related activities."[581]

Related Category 1 or 2 Project

- 127295703.2.10: Increase patient satisfaction

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and

[581] Available at: http://www.hcahpsonline.org. Centers for Medicare & Medicaid Services, Baltimore, MD. Accessed 11/6/2012.

2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

Patient satisfaction has been previously linked in the literature to a number of outcomes for patients and organizations both medical and financial. Better patient satisfaction has been associated with reduced risk of medical malpractice lawsuits. In one study patients in the bottom third of the Press Ganey benchmarks were 110 times more likely to experience malpractice law suits than those in the top third (Stelfox, Gandhi, Orav & Gustafson, 2005)—Parkland inpatient satisfaction scores have been consistently in the bottom third of Press Ganey's benchmarks. Law suits have also been shown to be significantly related to number of patient complaints (Press Ganey 2007). Service recovery and improved satisfaction scores can be expected to mitigate liability exposure, while better patient satisfaction has been shown to increase revenue. One study of physician practices determined that a 5% dissatisfaction rate equated to a $150,000 loss per physician in revenue (Drain & Kaldenberg, 1999). In 2006, malpractice payments averaged $308,593 (Kaiser Family Foundation 2007) per claim, largely due to poor communication between patients and physicians not negligence (23% of claims result from negligence; Phillips et.al. 2004)

Further studies indicate that improved patient satisfaction scores are associated with improved physician productivity and substantial declines in physician turnover. Improved patient satisfaction has been repeatedly associated with financial ROI (return on investment). All studies indicate increases in net operating margins with improved patient satisfaction, especially among those at the top deciles (Press Ganey 2010). Conversely, numerous studies report that satisfied patients cost less to care for because they use fewer resources and experience fewer stress complications. For example Duke Children's hospital increased patient and employee satisfaction yielded an average $4,389 reduction in cost per case (Meliones 2000), while Baptist Health System achieved and average reduction of $1,154 (Jackson, Sistrunk, & Staman, 2003). Moreover Baptist Health System, with an increased focus on patient satisfaction, experienced a length of stay drop of 1.3 days (Jackson, Sistrunk, & Staman, 2003). Overall, patients who are satisfied with their care do not complain as much, do not want to sue, have fewer complications, and are associated with improved staff and physician engagement. Given the financial impacts of improving patient satisfaction based on the above studies, this project may potentially return a cost savings to the organization of between $167,971,624 and $638,845,284 over four years (36389 inpatients per year*$1,154 or $4,389*4 years). Either amount of which is potentially well in excess of the $24,776,800 valuation, even without the potential reductions in malpractice lawsuit awards.

127295703.3.37	*3.IT-6.1*	*Percent improvement over baseline of HCAHPS inpatient satisfaction scores*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:	*127295703.2.10 – Increase patient satisfaction*		
Starting Point/Baseline:	*64% at 9 or 10 on "Overall Rating" question. (Source: CMS Hospital Compare Preview Report: Improving Care Trough Information—Inpatient Hospital Performance. Reporting Period: April 2011 through Mar 2012 Discharges)*		
Year 2 (10/1/2012 – 9/30/2013)	**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 – Establish position, recruit Service Excellence Manager and staff as appropriate, and document implementation plans Goal: Develop plan Data Source: Plan documentation Process Milestone Estimated Incentive Payment (max amount): $599,210	**Process Milestone 2** [P-4] Conduct Plan Do Check Act cycles Goal: Conduct PDSA study Data Source: Study documentation Process Milestone 2 Estimated Incentive Payment: $347,281 **Process Milestone 3** [P-5] Disseminate findings, including lessons learned and best practices to stakeholders Goal: Summarize findings Data Source: Findings report Process Milestone 3 Estimated Incentive Payment: $347,281	**Outcome Improvement Target 1** [IT-6.1] Increase patient satisfaction Improvement Target: Three percentage point improvement in percentage of patients rating 9 or 10 out of 10 on the HCAHPS "Overall Rating" question over baseline. Baseline: 64%, Baseline (April 2011-Mar 2012 CMS publically reported period). Data Source: Hospital Compare http://www.hospitalcompare.hhs.gov/ Outcome Improvement Target Estimated Incentive Payment (max amount): $1,114,530	**Outcome Improvement Target 2** [IT-6.1] Increase patient satisfaction Improvement Target: ~~Additional three~~ Six percentage point improvement in percentage of patients rating 9 or 10 out of 10 on the HCAHPS "Overall Rating" question over DY4 results. Baseline: 64%, Baseline (April 2011-Mar 2012 CMS publically reported period). Data Source: Hospital Compare http://www.hospitalcompare.hhs.gov/ Outcome Improvement Target Estimated Incentive Payment (max amount): $2,665,181
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $599,210	**Year 3 Estimated Outcome Amount:** $694,562	**Year 4 Estimated Outcome Amount:** $1,114,530	**Year 5 Estimated Outcome Amount:** $2,665,181
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $5,073,483			

Title of Outcome Measure (Improvement Target): IT-3.1 – All Cause 30-day Readmission Rate

Unique RHP outcome identification number(s): 127295703.3.38

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-3.1 – All Cause 30-day Readmission Rate for those Patients (Standalone Measure)

> **Numerator:** The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned
>
> **Denominator:** This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or older or (2) admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups.

Process Milestones

- DY2:
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, document implementation plans
  - P-2: Establish baseline rate
- DY3:
  - P-4: Conduct PDSA cycle
  - P-5: Disseminate findings, including best practices and lessons learned

Outcome Improvement Targets for each year

- DY4:
  - IT-3.12: All Cause 30-Day Readmission Rate. Improvement Target: 8.6%
- DY5:
  - IT-3.12: All Cause 30-Day Readmission Rate. Improvement Target: 8.5%

Rationale

As the Planning Protocol Category 3 states, the relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions

may result from circumstances surrounding the initial hospital stay.[582] Additionally, hospital readmissions in many cases are preventable. According to a 2009 study, nearly 20% of Medicare beneficiaries are re-hospitalized within 30 days after discharge, at an annual cost of $17 billion.[583] Causes of avoidable readmissions include hospital-acquired infections and other complications; premature discharge; failure to coordinate and reconcile medications; inadequate communication among hospital personnel, patients, caregivers, and community-based clinicians; and poor planning for care transitions.

Process milestones were chosen to insure the appropriate due diligence and planning is done in order to expand the program such that outcomes are improved and also to review opportunities to identify alternative and innovative ways to insure patients receive the post-acute care services they need regardless of their means to pay for such services.

The improvement targets were chosen based on the timeframe allowed to develop the plan and determine processes needed to collect and report data accurately and to insure findings are reported and shared across the organization as well as throughout the region.

Related Category 1 or 2 Project

- 127295703.1.6: Expand primary care capacity - Acute response clinic

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

[582] Goldfield N, McCullough E, Hughes, Tang A, Eastman B, Rawlins L, Averill R. 2008. "Identifying Potentially Preventable Readmissions." *Health Care Financing Review*. 30:1; pp75 -91.

[583] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N England J Med 2009;360: 1418-1428[Erratum, N England J Med 2011; 364:1582.]

127295703.3.38	*3.IT-3.1*	*All Cause 30-day Readmission Rate*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:		*127295703.1.6 – Expand existing primary care capacity – Acute response clinic*	
Starting Point/Baseline:		*8.74% (2,770/31,683 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans Goal: Develop plan Data Source: Plan Documentation Process Milestone 1 Estimated Incentive Payment (max amount): $446,684 **Process Milestone 2** [P-2] Establish baseline rate Goal: Determine baseline Data Source: Evidence-based literature, national benchmarks Process Milestone 2 Estimated Incentive Payment (max amount): $446,683		**Process Milestone 3** [P-4]: Conduct PDSA cycle Goal: Initiate PDSA study Data Source: Implementation plan Process Milestone 3 Estimated Incentive Payment (max amount): $517,764 **Process Milestone 4** [P-5]: Disseminate findings, including lessons learned and best practices Goal: Summarize findings and implement strategies Data Source: Report, other documentation Process Milestone 4 Estimated Incentive Payment (max amount): $517,765	**Outcome Improvement Target 1** [IT-3.1]: All Cause 30-day Readmissions Rate Improvement Target: Reduce All Cause Readmission Rate to 8.6% Baseline: 8.74% (2,770/31,683 patients) Goal: 8.6% readmissions rate Data Source: EHR, Claims, Internal Quality Report Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $1,661,663	**Outcome Improvement Target 2** [IT-3.1]: All Cause 30-day Readmissions Rate Improvement Target: Reduce All Cause Readmissions Rate to 8.5% Goal: 8.5% readmissions rate Data Source: EHR, claims, Internal Quality Report Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $3,973,542
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $893,367		**Year 3 Estimated Outcome Amount:** $1,035,529	**Year 4 Estimated Outcome Amount:** $1,661,663	**Year 5 Estimated Outcome Amount:** $3,973,542
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over Years 2-5):* $7,564,101				

Title of Outcome Measure (Improvement Target): IT-6.1 – Percent improvement over baseline for Patient Satisfaction Scores (related to how well providers communicate)

Unique RHP outcome identification number: 127295703.3.39

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-6.1 Percent improvement over baseline of inpatient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement: how well their doctors communicate; ***(Standalone measure)***

Numerator: Percent improvement in targeted patient satisfaction domain

Denominator: Number of patients who were administered the survey. Specific to this project: Total number patients answering the questions related to communication with clinicians (nurses/physicians).

Process Milestones:

- DY 2:
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Identify baseline
- DY 3:
    - P-5: Disseminate findings including lessons learned and best practices
    - P-7: Implement strategies

Outcome Improvement Targets:

- DY4: IT-6.1 – Percent improvement over baselines of patient satisfaction scores. Improvement targets include responses to the following questions:
    - Nurses explained in a way patient could understand ALWAYS: 78%
    - Physicians explained in a way patient could understand ALWAYS: 85%

- DY 5: IT- Percent improvement over baselines of patient satisfaction scores. Improvement Targets include responses to the following questions:
    - Nurses explained in a way patient could understand ALWAYS: 85%
    - Physicians explained in a way patient could understand ALWAYS: 90%

Rationale

It is the intention to improve health literacy for our patients. Parkland's population (290,000 patients annually) includes more than 53% Hispanic patients of which 39% state their primary language is Spanish. Based on the most recent patient satisfaction survey results, only 69.1% felt nurses explained things in a way they could understand and 76.5% felt their physicians always explained things in a way they understood. Patients who do not understand their care/treatment are less likely to have better outcomes for their care. If communication can be improved, it is more likely that treatment/medication regiments will be followed and will improve the health of the patient.

More than 30% of Parkland's current population does not feel they understand their care/treatment through provider communication. Implementing a Health Care Literate Model can improve patient satisfaction as well as adherence to treatment potentially reducing unnecessary utilization of ED and other services.

Related Category 1 or 2 Project

- 127295703.1.7: Enhance Interpretation Services

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

127295703.3.39	*3.IT-6.1*	*Percent Improvement over baseline of patient satisfaction (specific to communication with provider)*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:		*127295703.1.7 – Enhance Interpretation Services*	
Starting Point/Baseline:		*Patient Survey questions: 1) Nurses explain in way I can understand always: 69.1%* *2) Physicians explain in a way I can understand always: 76.5%*	
Year 2 **(10/1/2012 – 9/30/2013)**		**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] Complete a planning process in order to do appropriate planning for the implementation of major infrastructure development or process redesign. Goal: Develop plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment: $405,828 **Process Milestone 2** [P-2]: Establish baseline rate Goal: Determine baseline Data Source: Evidence-based literature, national benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $405,829		**Milestone 3** [P-5] Disseminate findings including lessons learned and best practices Goal: Summarize findings Data Source: Report of findings Process Milestone 3 Estimated Incentive Payment: $470,408 **Process Milestone 4** [P-7]: Implement strategies Goal: Implementation of strategies Data Source: Implementation plan and documentation of milestones Process Milestone 4 Estimated Incentive Payment: $470,408	**Outcome Improvement Target 1** [IT-11.6]: Improve communication between patient and provider (as determined by Patient Sat. Scores in target population) Improvement Target: • Nurses explained in a way patient could understand ALWAYS: 78% • Physicians explained in a way patient could understand ALWAYS: 85% Baseline: • Nurses explained in a way patient could understand ALWAYS: 69.1% • Physicians explained in a way patient could understand ALWAYS: 76.5% Data Source: Administrative data, Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment: $1,509,682	**Outcome Improvement Target 2** [IT-11.6]: Improve communication between patient and provider (as determined by Patient Satisfaction Scores in target population with identified disparity) Improvement Target: • Nurses explained in a way patient could understand ALWAYS: 85% • Physicians explained in a way patient could understand ALWAYS: 90% Data Source: Administrative data, Patient Survey Outcome Improvement Target 2 Estimated Incentive Payment: $3,610,108

127295703.3.39	*3.IT-6.1*	*Percent Improvement over baseline of patient satisfaction (specific to communication with provider)*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:		*127295703.1.7 – Enhance Interpretation Services*	
Starting Point/Baseline:		*Patient Survey questions: 1) Nurses explain in way I can understand always: 69.1%* *2) Physicians explain in a way I can understand always: 76.5%*	
Year 2 (10/1/2012 – 9/30/2013)		**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: $811,657		**Year 3 Estimated Outcome Amount:** $940,816	**Year 4 Estimated Outcome Amount:** $1,509,682	**Year 5 Estimated Outcome Amount:** $3,610,108
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $6,872,263				

Title of Outcome Measure (Improvement Target): IT-1.1 – Third Next Available Appointment – Family Medicine Clinic

Unique RHP outcome identification number: 127295703.3.40

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT - 1.1 – Third Next Available Appointment (Non-standalone Measure)

Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department.

Denominator: This measure applies to providers within a reported clinic and/or department

Inclusions: This measure applies to providers* within a reported clinic and/or department**

*Providers:

A. All providers are included. Full-time and part-time providers are included, regardless of the number of hours s/he practices per week.
    1. Providers who job share are counted as one (ie they share one schedule, and/or they work separate day & share coverage of one practice).
    2. When measuring a care team, each member of the care team is counted separately (i.e., MD, NP, PA).
    3. If a provider is practicing in a specialty other than the one which s/he is board certified, the provider should be included in the specialty in which s/he is practicing.
    4. For providers practicing at more than 1 location, measure days to third next available for only the provider's primary location as long as the provider is at that location 51%+ of their time.
    5. New providers who started seeing patients during the reporting period and have an active schedule should be included.
B. Locums are included in the measure only if they are assigned to a specific site for an extended period of time (4+ weeks) & provide continuity care to patient panel
C. Mid-Level providers are included in the measure (NP, PA, CNM).
    6. Mid-Level providers should have continuity practice and their own schedule available to see patients.

D. Resident Providers are to be included if they have an active schedule AND are considered a Primary Care Provider within the organization.
E. Providers with closed practices should be included. They still have to schedule their current patients. In addition, it may not be clear when they start seeing new patients again.

**Departments:

3. Primary Care
    a. General Internal Medicine
    b. Family Practice
    c. Pediatrics with the focus on generalists, not specialists
    d. Med/Peds (physicians who see both adults and children)
4. Specialty Care
    a. Obstetrics (Physical exam - New OB visit)

Exclusions:

- Exclude clinicians who do not practice for an extended period of time (greater than 4 weeks) due to maternity leave, sabbatical, family medical leave.
- Mid-Level providers who function only as an "extender," overflow to another practice, or urgent care should not be included.
- Exclude Resident Providers if they are not considered a Primary Care Provider, have an inconsistent schedule, and a restricted patient panel.

Data Collection: Sample all physicians on team the same day of the week, once a week. Count the number of days between a request for an appointment (e.g., enter dummy patient) with a physician and the third next available appointment for a new patient physical, routine exam, or return visit exam. Report the average number of days for all physicians sampled. Note: Count calendar days (e.g. include weekends) and days off. Do not count any saved appointments for urgent visits (since they are "blocked off" on the schedule.) The data collection can be done manually or electronically. Manual collection means looking in the schedule book and counting from the "index" (day when "dummy" appointment is requested) to day of third available appointment. Some electronic scheduling systems can be programmed to compute number of days automatically.

Process Milestones:

- DY2:
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- P-2: Establish baseline

- DY3:
  - P-5: Disseminate findings, including lessons learned and best practices
  - P-7: Implement strategies to improve access to Family Medicine

Outcome Improvement Targets:

- DY4:
  - IT-1.1: Third next available appointment. Improvement Target: 22 days
- DY5:
  - IT-1.1: Third next available appointment. Improvement Target: 20 days

Rationale

Access is a measure of the patient's ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit. Counting the third next available appointment is the healthcare industry's standard measure of access to care and indicates how long a patient waits to be seen. Access to healthcare is important to the quality of healthcare outcomes. Patients who can promptly schedule appointments with their healthcare providers will have higher satisfaction, will likely return to work sooner, and may have better medical outcomes.

Related Category 1 or 2 Projects

- 127295703.2.10: Expand/Enhance Medical Home Model – Family Medicine

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

127295703.3.40	*3.IT-1.1*	*Third Next Available Appointment*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:		*127295703.2.11 - Expand Medical Home model – Campus-based Primary Care clinics*	
Starting Point/Baseline:		*28 days*	
Year 2 (10/1/2012 – 9/30/2013)		**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] Complete a planning process in order to do appropriate planning for the implementation of major infrastructure development or process redesign. Goal: Develop plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment: $77,171 **Process Milestone 2** [P-2] Establish baseline Goal: Determine baseline Data Source: Evidence-based literature, other documentation Process Milestone 2 Estimated Incentive Payment: $77,171		**Process Milestone 3** [P-5] Disseminate findings including lessons learned and best practices to stakeholders Goal: Summarize findings Data Source: Report of findings Process Milestone 3 Estimated Incentive Payment: $89,451 **Process Milestone 4** [P-7]: Implement strategies to improve access to Family Medicine Goal: Implementation of strategies Data Source: Implementation plan and documentation of milestones Process Milestone 4 Estimated Incentive Payment: $89,451	**Outcome Improvement Target 1** [IT-1.1]: Third next available appointment Improvement Target: Reduce third next available appointment to 25 days in Family Medicine Baseline: 28 days (FY12) Goal: 25 days Data Source: Scheduling report Outcome Improvement Target 1 Estimated Incentive Payment*:* $287,076	**Outcome Improvement Target 2** [IT-1.1]: Reduce wait time for third next available appointment Improvement Target: Reduce third next available appointment to 20 days in Family Medicine Goal: 20 days Data Source: Scheduling report Outcome Improvement Target 2 Estimated Incentive Payment*:* $686,486
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $154,342		**Year 3 Estimated Outcome Amount:** $178,902	**Year 4 Estimated Outcome Amount:** $287,076	**Year 5 Estimated Outcome Amount:** $686,486
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,306,806				

Title of Outcome Measure (Improvement Target): IT-1.12 – Diabetes Care: Retinal Eye Exam

Unique RHP outcome identification number: 127295703.3.41

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-1.12 - Diabetes Care: Retinal Eye Exam (NQF 0055) (Non-standalone Measure)

Numerator: An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

a) A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, or

b) A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year

Denominator: Members 18 to 75 year of age as of December 31 of the measurement year with diabetes (type 1 or type 2)

Process Milestones:

- DY2:
    - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-2: Establish a baseline rate
- DY3:
    - P-7: Implement intervention to provide retinal scans

Outcome Improvement Targets:

- DY4:
    - IT-1.12: Increase percentage of Family Medicine and Primary Care Internal Medicine (PCIM) patients with diabetes had a retinal exam in the recommended time-frame. Improvement Target: 60%

- DY 5:
    - IT-1.12: Increase percentage of Family Medicine and Primary Care Internal Medicine (PCIM) patients with diabetes had a retinal exam in the recommended time-frame. Improvement Target: 80%

Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 25.8 million Americans have diabetes, of which about 7 million are undiagnosed[584]. In addition, diabetes was the seventh leading cause of death in Americans of all ages in 2009, and the fifth leading cause of death among the "young old," ages 65-79[585]. Diabetic retinopathy, one of the leading causes of blindness in adults, can be treated if detected and addressed in the early stages[586].

Process milestones were chosen due to promote chronic disease management and the use of the chronic disease management mode in the primary care clinics. In DY2, we will complete the process currently under way of installing retinal scan cameras and training clinicians in their use. In DY3, we will use current data to establish a baseline from which to set goals for DY3, DY4 and DY5. Once the retinal scan cameras and the necessary clinical teams are in place and trained, we will begin routine use of the retinal cameras for diabetic eye exams. We will also study successes and failures for any potential improvements.

Related Category 1 and/or 2 Projects

- 127295703.2.10: Expand Medical Home model – Family Medicine

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

[584] US Department of Health and Human Services, C.f.D.C.a.P. National Diabetes Fact Sheet 2011. 2011; Available from: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

[585] National Vital Statistics System, C.N., Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 5-year age group, by race/ sex: US, 1999-2009, C.f.D.C.a.P. US Department of Health and Human Services, Editor 2009.

[586] American Optometric Association. Diabetes is the leading cause of blindness among most adults. 2012 [cited 2012 October 19]; Available from: http://www.aoa.org/x6814.xml.

127295703.3.41	*3.IT-1.12*	*Diabetes – Retinal Eye Exam*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.2.11 – Expand Medical Home model – Campus-based Primary Care clinics*		
Starting Point/Baseline:		*48% (235/483 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] Complete a planning process in order to do appropriate planning for the implementation of major infrastructure development or process redesign. Goal: Develop plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment: $77,171 **Process Milestone 2** [P-2]: Establish a baseline rate among established patients, in order to measure improvement. Goal: Determine baseline Data Source: Evidence-based literature, national benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $77,171		**Process Milestone 3** [P-7] Implement intervention to provide retinal scans Goal: Implement interventions Data Source: Scheduling report Process Milestone 3 Estimated Incentive Payment: $178,902	**Outcome Improvement Target 1** [IT-1.12]: Increase percentage of established diabetic patients who have retinal exam Improvement Target: 60% of diabetic patients have eye exams annually Baseline: 48% (235/483) Goal: 60% of patients to have retinal eye exams Data Source: Administrative data Outcome Improvement Target 1 Estimated Incentive Payment*:* $287,076	**Outcome Improvement Target 2** [IT-1.12]: Increase percentage of established diabetic patients who have had retinal exam Improvement Target: 80% of diabetic patients have eye exams annually Goal: 80% of patients to have retinal eye exams Data Source: Administrative data Outcome Improvement Target 2 Estimated Incentive Payment*:* $686,486
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $154,342		**Year 3 Estimated Outcome Amount:** $178,902	**Year 4 Estimated Outcome Amount:** $287,076	**Year 5 Estimated Outcome Amount:** $686,486
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,306,806				

Title of Outcome Measure (Improvement Target): IT-1.13 – Diabetes Care: Foot Exam

Unique RHP outcome identification number: 127295703.3.42

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT - 1.13 - Diabetes Care: Foot Exam (NQF 0056) (Non-standalone Measure)

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)

Process Milestones:

- DY 2:
    - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
    - P-3: Establish baseline rate
- DY 3:
    - P-7: Implement intervention to provide foot exams

Outcome Improvement Targets:

- DY4:
    - IT-1.13: Percentage of established diabetic patients who have foot exam in the recommended time-frame. Improvement Target: 60%
- DY 5:
    - IT-1.13: Percentage of established diabetic patients who have foot exam in the recommended time-frame. Improvement Target: 80%

Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 25.8 million Americans have diabetes, of which about 7 million are undiagnosed[587]. In addition, diabetes was the seventh leading cause of death in Americans of all ages in 2009, and the fifth leading cause of death among the "young old," ages 65-79[588]. Foot ulcers can be prevented if detected and addressed in the regular health visits.

Process milestones were chosen due to promote chronic disease management and the use of the chronic disease management mode in the primary care clinics. Improvement targets were chosen to insure success in providing foot exams to prevent further complications.

Related Category 1 or 2 Project

- 127295703.2.11 – Expand Medical Home Model – Family Medicine Clinic

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

[587] US Department of Health and Human Services, C.f.D.C.a.P. National Diabetes Fact Sheet 2011. 2011; Available from: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

[588] National Vital Statistics System, C.N., Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 5-year age group, by race and sex: US, 1999-2009, C.f.D.C.a.P. US Department of Health and Human Services, Editor 2009.

127295703.3.42	*3.IT-1.13*	*Diabetes – Foot Exam*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.2.11 – Expand Medical Home model – Campus-based Primary Care Clinics*		
Starting Point/Baseline:		*21% (105 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] Complete a planning process in order to do appropriate planning for the implementation of major infrastructure development or process redesign. Goal: Develop plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment: $77,171 **Process Milestone 2** [P-2]: Establish a baseline rate among established patients, in order to measure improvement. Goal: Determine baseline Data Source: Evidence-based literature, national benchmarks, other documentation Process Milestone 2 Estimated Incentive Payment: $77,171		**Process Milestone 3** [P-7] Implement intervention to provide foot exams Goal: Implement interventions Data Source: Scheduling report Process Milestone 3 Estimated Incentive Payment: $178,903	**Outcome Improvement Target 1** [IT-1.13]: Increase percentage of established diabetic patients who have foot exam Improvement Target: 60% of diabetic patients have foot exam annually Baseline: 21% (105 patients) Goal: 60% of patients to have foot exam Data Source: Administrative data Outcome Improvement Target 1 Estimated Incentive Payment*:* $287,076	**Outcome Improvement Target 2** [IT-1.13]: Increase percentage of established diabetic patients who have had foot exam Improvement Target: 80% of diabetic patients have foot exam annually Goal: 80% of patients to have foot exam Data Source: Administrative data Outcome Improvement Target 2 Estimated Incentive Payment*:* $686,486
Year 2 Estimated Outcome Amount: $154,342		**Year 3 Estimated Outcome Amount:** $178,903	**Year 4 Estimated Outcome Amount:** $287,076	**Year 5 Estimated Outcome Amount:** $686,486
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,306,807				

Title of Outcome Measure: IT-3.12 – Other: All Cause 30-day Readmission Rate for Patients enrolled in Outpatient Parenteral Antimicrobial Therapy (OPAT) Program

Unique RHP outcome identification number(s): 127295703.3.43

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-3.12 – All Cause 30-day Readmission Rate for those Patients enrolled in OPAT Program (Standalone Measure)

Numerator: Number of readmissions for patients 18 years and older for any cause from index admission.
Denominator: Number of admissions for patients 18 years and older for patients discharged from hospital with a PICC line to administer their antibiotics at home

Process Milestones

- DY2:
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, document implementation plans
  - P-2: Establish baseline rates
- DY3:
  - P-5: Disseminate findings, including best practices and lessons learned
  - P-7: Implement strategies

Outcome Improvement Targets for each year

- DY4:
  - IT-3.12: Other All Cause Readmission Rate. Improvement Target: Reduce All Cause 30-Day Readmission Rate for OPAT patients to ~~22%~~ 25%
- DY5:
  - IT-3.12: Other All Cause Readmission Rate. Improvement Target: Reduce All Cause 30-Day Readmission Rate for OPAT patients to ~~17%~~ 20%

Rationale

As the Planning Protocol Category 3 states, the relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions

may result from circumstances surrounding the initial hospital stay.[589] Additionally, hospital readmissions in many cases are preventable. According to a 2009 study, nearly 20% of Medicare beneficiaries are re-hospitalized within 30 days after discharge, at an annual cost of $17 billion.[590] Causes of avoidable readmissions include hospital-acquired infections and other complications; premature discharge; failure to coordinate and reconcile medications; inadequate communication among hospital personnel, patients, caregivers, and community-based clinicians; and poor planning for care transitions.

Patients who are discharged with PICC lines to administer their medications at home are at risk for readmission for several reasons including infection at the PICC site, abnormal blood levels, etc. Targeting All Cause readmissions will provide the best metric to insure that all readmissions for this specific population are reviewed and findings are utilized for further improvements to the program.

Process milestones were chosen to insure the appropriate due diligence and planning is done in order to expand the program such that outcomes are improved and also to review opportunities to identify alternative and innovative ways to insure patients receive the post-acute care services they need regardless of their means to pay for such services. Improvement targets were chosen based on the timeframe allowed to develop the plan and determine processes needed to collect and report data accurately and to insure findings are reported and shared across the organization as well as throughout the region.

Related Category 1 or 2 Projects

- 127295703.2.12: Apply Process Improvement Methodology to Improve Quality/ Efficiency – Outpatient Parenteral Antimicrobial Therapy (OPAT) Program

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

[589] Goldfield N, McCullough E, Hughes, Tang A, Eastman B, Rawlins L, Averill R. 2008. "Identifying Potentially Preventable Readmissions." *Health Care Financing Review*. 30:1; pp75 -91.

[590] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N England J Med 2009;360: 1418-1428[Erratum, N England J Med 2011;364:1582.]

127295703.3.43	*3.IT-3.12*	*All Cause 30-Day Readmission Rate for Patients enrolled in OPAT Program*		
Parkland Health & Hospital System				*127295703*
Related Category 1 or 2 Projects:		*127295703.2.12 – Apply PI Methodology to Improve Quality/Efficiency – OPAT Program*		
Starting Point/Baseline:		*FY2011: 65% (168 readmissions for OPAT 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans Goal: Develop plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment (max amount): $394,933 **Process Milestone 2** [P-2]: Establish baseline rates Goal: Determine baseline Data Source: Evidence-based literature, national benchmarks Process Milestone 2 Estimated Incentive Payment (max amount): $394,934		**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices Goal: Summarize findings Data Source: Findings Report Process Milestone 3 Estimated Incentive Payment (max amount): $457,779 **Process Milestone 4** [P-7] Implement strategies Goal: Implement strategies Data Source: Implementation plan and documentation of milestones Process Milestone 4 Estimated Incentive Payment (max amount): $457,780	**Outcome Improvement Target 1** [IT-3.12]: All Cause 30-day Readmissions Rate for Patients enrolled in OPAT program Improvement Target: Improve All Cause 30-day Readmission Rate to 25% Baseline: 65% (168 readmissions for OPAT patients) Goal: Improve rate to 25% Data Source: EHR, Claims, Internal Report Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $1,469,153	**Outcome Improvement Target 2** [IT-3.12]: All Cause 30-day Readmissions Rate for Patients enrolled in OPAT program Improvement Target: Improve All Cause 30-day Readmission Rate to 20% Goal: Improve rate to 20% Data Source: EHR, Claims, Internal Report Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $3,513,193
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $789,867		**Year 3 Estimated Outcome Amount:** $915,559	**Year 4 Estimated Outcome Amount:** $1,469,153	**Year 5 Estimated Outcome Amount**: $3,513,193
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $6,687,772				

Title of Outcome Measure (Improvement Target): IT-4.8 – Sepsis Mortality (new)

Unique RHP outcome identification number(s): 127295703.3.44 (new)

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Outcome Measure Description

IT-4.8 – Sepsis Mortality (Standalone Measure)

Numerator: Number of patients expiring during current month hospitalization with sepsis, severe sepsis or septic shock and/or an infection or organ dysfunction

Denominator: Number of patients identified that month with sepsis, severe sepsis or septic shock and/or infection or organ dysfunction.

Data Source: Provider data

Process Milestones

- DY2:
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines, document implementation plans
  - P-2: Establish baseline rates

- DY3:
  - P-5: Disseminate findings, including best practices and lessons learned
  - P-7: Implement strategies

Outcome Improvement Targets for each year

- DY4: Improvement Target (DY4 baseline)
  - IT-4.2: Reduce Sepsis Mortality rate 5% from baseline

- DY5: Improvement Target
  - IT-4.2: Reduce Sepsis Mortality additional 5% from DY4

Rationale

According to the Global Sepsis Alliance, "Sepsis cause more deaths per year than prostate cancer, breast cancer and HIV/AIDS combined. Globally 18 million cases of sepsis occurs each year and many experts in the field believe sepsis is actually responsible for the majority of mortality associated with HIV/AIDS, malaria, pneumonia and other infections acquired in the

community, healthcare settings and by traumatic injury."[591] Research finds that potential/suspected sepsis can be controlled and with efficient care and timely interventions including antimicrobials and IV fluids, the risk of death is almost cut in half. [592]

The Greater New York Hospital Association's STOP Sepsis collaborative has seen an 18% improvement in the sepsis mortality rate across the region from January of 2011 to June of 2012 by utilizing best practices such as improving communication between the ED and ICUs and appointment a designated point person to education staff on sepsis protocols. The IHI website claims that a 25% reduction in sepsis mortality is possible by adopting the severe sepsis care bundles.

Process milestones were chosen to insure the appropriate due diligence and planning is done in order to determine the clinical protocols that are appropriate in screening patients for sepsis in the ED and inpatient setting. Improvement targets were chosen based on the timeframe allowed to develop the plan and determine processes needed to collect and report data accurately and to insure findings are reported and shared across the organization as well as throughout the region.

Related Category 1 or 2 Projects

- 127295703.2.6: Apply Process Improvement Methodology to Improve Quality/ Efficiency

Outcome Measure Valuation

The valuation for Category 1 and 2 projects was completed by using literature, historical provider level data or other evidence based resources. RHP9 Performing Providers defined valuation criteria that were then given weights so that each project could be scored. The score provided a guideline for valuations based on the funding allocation for each Category and 1 and 2 project. The Category 1 and 2 project valuations provided the valuation percentage for Category 3 outcomes as defined by the PFM requirements.

[591] Global Sepsis Alliance-Sepsis Fact Sheet: http://www.globalsepsisalliance.org/world/Sepsis_Factsheet.pdf. 2012

[592] Rivers, E, et al. "Early Goal-Directed Therapy in treatment of severe sepsis and septic shock." NEJM, 2001. 345 (19): p. 1368-1377.

127295703.3.44	*3.IT-4.8*	*Sepsis Mortality*	
Parkland Health & Hospital System			*127295703*
Related Category 1 or 2 Projects:		*127295703.2.6 – Apply Process Improvement Methodology to Improve Quality/Efficiency - PPCs*	
Starting Point/Baseline:		*19% (214/1,131 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans Goal: Develop plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment (max amount): $118,480 **Process Milestone 2** [P-2]: Establish baseline rates Goal: Determine baseline Data Source: Baseline analysis Process Milestone 2 Estimated Incentive Payment (max amount): $118,481		**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices Goal: Summarize findings Data Source: Findings Report Process Milestone 3 Estimated Incentive Payment (max amount): $137,333 **Process Milestone 4** [P-7] Implement strategies Goal: Implementation of strategies Data Source: Documentation of plan milestones Process Milestone 4 Estimated Incentive Payment (max amount): $137,334	**Outcome Improvement Target 1** [IT-4.2]: Improve SSI Rate Improvement Target: Improve Sepsis Mortality by Baseline: 19%(214/1,131 patients) Goal: 5% reduction in rate Data Source: Internal Quality Report Outcome Improvement Target 1 Estimated Incentive Payment (max amount): $440,746	**Outcome Improvement Target 2** [IT-4.2]: Improve SSI Rate Improvement Target: Improve Sepsis Mortality by Goal: Additional 5% reduction from DY4 Data Source: Internal Quality Report Outcome Improvement Target 2 Estimated Incentive Payment (max amount): $1,053,957
Year 2 Estimated Outcome Amount (and incentive payments amounts form each milestone/outcome improvement target): $236,961		**Year 3 Estimated Outcome Amount:** $274,667	**Year 4 Estimated Outcome Amount:** $440,746	**Year 5 Estimated Outcome Amount:** $1,053,957
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over Years 2-5):* $2,006,331				

Project Title: Expansion of Senior Dental Student Externship Program
RHP Project Identifier: 009784201.3.1
Performing Provider: Baylor College of Dentistry / 009784201

Outcome Measure Description:

The chosen outcome measure is one customized for this project: **IT-7.10 Percentage of new dental graduates entering practice in rural and/or underserved areas.** The numerator will be the number of students participating each year, with the total number of students in the class as the denominator. The baseline, or current percentage is approximately 5% of the class. The improvement targets are as follows; DY2: 7%, DY3: 8%, DY4: 9% and DY5: 10%.

The premise underlying training dental students in externships in rural and/or underserved areas is the potentially increased probability that they will enter practice in this type of area. Therefore, increasing the number of graduates with training experience in rural and/or underserved areas is one way of addressing the disadvantageous distribution of dentists in the state that currently exists.

Rationale:
The most straightforward way to measure progress in the project is simply documenting the number of students participating in the program. The externship program is already in operation, so the baselines are known and improvement targets can be specified for each year from DY2 going forward.

Outcome Measure Valuation:
The valuation of this project is based primarily on the value of the care provided by the students during their externship trainings. The population addressed will be patients in rural/underserved areas who will be treated by the trainees, and will number approximately 8,000 over the four years of the project. Estimating the number students participating annually, and their production capacity, we conservative estimate an annual total of 2,250 patient encounters. Based on data from non-profit providers in the Dallas area and some of the current externship sites, the average cost of each encounter is approximately $125. A multiplier of 2.7, based on data from The Original National Dental Advisory Service 2012 (Yale Wasserman, D.M.D. Medical Publishers, Ltd. NDAS 30th Edition), will be applied to the average encounter cost. Calculation of this multiplier is based on Medicaid dental reimbursements by procedure code versus the NDAS Comprehensive Fee Report, which is a nationwide marketplace analysis of usual and customary fees. The multiplier is also a way to incorporate the benefit to the community, in terms of addressing a high-priority community need, the size of the population served and the cost avoidance, e.g. reduced school absences, improved academic performance in children and decreased workdays lost due to dental complaints. Taken together, these figures estimate a total of $759,375 in treatment rendered during each year of the project.

009784201.3.1	*3. IT-7.10*	*Percentage of new dental graduates entering practice in rural and/or underserved areas*	
Baylor College of Dentistry		*9784201*	
Related Category 1 or 2 Projects:	*009784201.1.1*		
Starting Point/Baseline:	*5%*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1 Project planning – identify current capacity and needed resources and document implementation plans Milestone 1 Estimated Incentive Payment: $18,984 Outcome Improvement Target 1: IT-7.10 Percentage of new dental graduates entering practice in rural and/or underserved areas Improvement Target: 7% Data Source: Self-report, dental licensing information Outcome Improvement Target 1 Estimated Incentive Payment: $18,984	Outcome Improvement Target 2: IT-7.10 Percentage of new dental graduates entering practice in rural and/or underserved areas Improvement Target: 8% Data Source: Self-report, dental licensing information Outcome Improvement Target 2 Estimated Incentive Payment: $75,937	Outcome Improvement Target 3: IT-7.10 Percentage of new dental graduates entering practice in rural and/or underserved areas Improvement Target: 9% Data Source: Self-report, dental licensing information Outcome Improvement Target 3 Estimated Incentive Payment: $113,906	Outcome Improvement Target 4: IT-7.10 Percentage of new dental graduates entering practice in rural and/or underserved areas Improvement Target: 10% Data Source: Self-report, dental licensing information Outcome Improvement Target 4 Estimated Incentive Payment: $151,875
Year 2 Estimated Outcome Amount: $37,968	Year 3 Estimated Outcome Amount: $75,937	Year 4 Estimated Outcome Amount: $113,906	Year 5 Estimated Outcome Amount: $151,875
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $379,686			

Project Title: Expansion of Dallas County dental clinic hours
RHP Project Identifier: 009784201.3.2
Performing Provider: Baylor College of Dentistry / 009784201

Outcome Measure Description:

IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal *(Non-standalone measure)*

Numerator: Number of children age 6-9 with a dental sealant on at least one permanent first molar within the measurement period
Denominator: Total number of children age 6-9 that have seen a dental provider within the measurement period
Data Source: EHR, Claims
Rationale/Evidence: Children who have regular access to a dental provider are more likely to have received preventive dental services such as sealant placement.
Improvement targets are as follows; DY2: 28%, DY3: 29%, DY4: 31% and DY5: 32%.

Data Source: EHR, Claims
Rationale/Evidence: Children who have regular access to a dental provider are more likely to have received preventive dental services such as fluoride varnish application
Improvement targets are as follows; DY2: 28%, DY3: 29%, DY4: 31% and DY5: 32%.

Rationale:
Approximately 80% of the population seen in the clinics involved in this project includes children age 6-20. Dental sealants are second only to community water fluoridation as an effective preventive strategy for caries. Dental sealants and fluoride varnish are highly effective preventive treatments in young children, and the patient population targeted by the sealant program is children age 6-9, thus outcome measures related to sealants and topical fluoride application are appropriate.

Project metrics will be assessed by collection of oral health surveillance data using the appropriate module of the Basic Screening Survey. Key oral health status indicators relating to project outcome milestones will be captured directly onsite at Dallas elementary school campuses for children enrolled in Kindergarten, second and third grade. Direct data entry will be performed in the school-based sealant program using the SmilesMaker software, a modified version of the CDC's S.E.A.L.S. data collection tool. In both modules of the Basic Screening Survey, the assessment includes age-appropriate oral measures of oral health status including: untreated decay, urgency of care, caries experience, dental sealants and early childhood caries.

Outcome Measure Valuation:

The valuation of this project is based primarily on the value of the care provided by the students during their rotations. The population seen in the clinics is overwhelmingly disadvantaged, underserved and of low socioeconomic status, and will number approximately 10,000 over the four years of the project. Estimating the number students participating annually and their production capacity, we calculate an annual total of 3,300 patient encounters in DY2 and approximately 10,500 each year thereafter. Based on data from non-profit providers in the Dallas area and some of the current externship sites, the average cost of each encounter is approximately $125. A multiplier of 2.7, based on data from The Original National Dental Advisory Service 2012 (Yale Wasserman, D.M.D. Medical Publishers, Ltd. NDAS 30th Edition), will be applied to the average encounter cost. Calculation of this multiplier is based on Medicaid dental reimbursements by procedure code versus the NDAS Comprehensive Fee Report, which is a nationwide marketplace analysis of usual and customary fees. The multiplier is also a way to incorporate the benefit to the community, in terms of addressing a high-priority need, reducing school absences, improving academic performance in children and decreasing workdays lost due to dental complaints, the size of the population served and cost avoidance, as well as the benefit of additional clinical training for the dental students. Altogether, these figures estimate a total of $1M in treatment during the first year of the project, and in excess of $3.6M each year thereafter.

009784201.3.2	*3.IT-7.1*	*Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth*	
Baylor College of Dentistry		*9784201*	
Related Category 1 or 2 Projects:	*009784201.1.2*		
Starting Point/Baseline:	*50%*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1 Project planning – identify current capacity and needed resources and document implementation plans Milestone 1 Estimated Incentive Payment: $8,837 Outcome Improvement Target 1: IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth Improvement Target: 28% Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment: $8,837	Outcome Improvement Target 2: IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth Improvement Target: 29% Data Source: EHR, claims Outcome Improvement Target 2 Estimated Incentive Payment: $113,197	Outcome Improvement Target 3: IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth Improvement Target: 31% Data Source: EHR, claims Outcome Improvement Target 3 Estimated Incentive Payment: $195,108	Outcome Improvement Target 4: IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth Improvement Target: 32% Data Source: EHR, claims Outcome Improvement Target 4 Estimated Incentive Payment: $260,145
Year 2 Estimated Outcome Amount: $17,674	Year 3 Estimated Outcome Amount: $113,197	Year 4 Estimated Outcome Amount: $195,108	Year 5 Estimated Outcome Amount: $260,145
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $586,124			

Project Title: Expansion of Dallas County dental clinic hours
RHP Project Identifier: 009784201.3.3
Performing Provider: Baylor College of Dentistry / 009784201

Outcome Measure Description:

IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period. *(Non-standalone measure)* Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - Percentage of children, age 0-6 years, who received a fluoride varnish application during the measurement period.

Numerator: Number of children age 0-6 years that have received at least one fluoride varnish application during the measurement period
Denominator: Total number of children age 0-6 years that have been seen by a primary care or dental provider.
Data Source: EHR, Claims
Rationale/Evidence: Children who have regular access to a dental provider are more likely to have received preventive dental services such as fluoride varnish application.
Improvement targets are as follows; DY2: 28%, DY3: 29%, DY4: 31% and DY5: 32%.

Rationale:
Approximately 80% of the population seen in the clinics involved in this project includes children age 6-20. Dental sealants are second only to community water fluoridation as an effective preventive strategy for caries. Dental sealants and fluoride varnish are highly effective preventive treatments in young children, and the patient population targeted by the sealant program is children age 6-9, thus outcome measures related to sealants and topical fluoride application are appropriate.

Project metrics will be assessed by collection of oral health surveillance data using the appropriate module of the Basic Screening Survey. Key oral health status indicators relating to project outcome milestones will be captured directly onsite at Dallas elementary school campuses for children enrolled in Kindergarten, second and third grade. Direct data entry will be performed in the school-based sealant program using the SmilesMaker software, a modified version of the CDC's S.E.A.L.S. data collection tool. In both modules of the Basic Screening Survey, the assessment includes age-appropriate oral measures of oral health status including: untreated decay, urgency of care, caries experience, dental sealants and early childhood caries.

Outcome Measure Valuation:
The valuation of this project is based primarily on the value of the care provided by the students during their rotations. The population seen in the clinics is overwhelmingly disadvantaged, underserved and of low socioeconomic status, and will number approximately 10,000 over the four years of the project. Estimating the number students participating

annually and their production capacity, we calculate an annual total of 3,300 patient encounters in DY2 and approximately 10,500 each year thereafter. Based on data from non-profit providers in the Dallas area and some of the current externship sites, the average cost of each encounter is approximately $125. A multiplier of 2.7, based on data from The Original National Dental Advisory Service 2012 (Yale Wasserman, D.M.D. Medical Publishers, Ltd. NDAS 30th Edition), will be applied to the average encounter cost. Calculation of this multiplier is based on Medicaid dental reimbursements by procedure code versus the NDAS Comprehensive Fee Report, which is a nationwide marketplace analysis of usual and customary fees. The multiplier is also a way to incorporate the benefit to the community, in terms of addressing a high-priority need, reducing school absences, improving academic performance in children and decreasing workdays lost due to dental complaints, the size of the population served and cost avoidance, as well as the benefit of additional clinical training for the dental students. Altogether, these figures estimate a total of $1M in treatment during the first year of the project, and in excess of $3.6M each year thereafter.

009784201.3.3	*3.IT-7.3*	*Early Childhood Caries (fluoride applications): Primary Caries prevention Intervention as Offered by Primary Care Providers, including Dentists. -Percentage of children age 0-6 who received a fluoride varnish application during the measurement period*		
Baylor College of Dentistry			*9784201*	
Related Category 1 or 2 Projects:		*009784201.1.2*		
Starting Point/Baseline:		*50%*		
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1 Project planning – identify current capacity and needed resources and document implementation plans Milestone 1 Estimated Incentive Payment: $8,837 Outcome Improvement Target 1: IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period Improvement Target: 28% Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment: $8,837		Outcome Improvement Target 2: IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period Improvement Target: 29% Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment: $113,197	Outcome Improvement Target 3: IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period Improvement Target: 31% Data Source: EHR, claims Outcome Improvement Target 3 Estimated Incentive Payment: $195,108	Outcome Improvement Target 4: IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period Improvement Target: 32% Data Source: EHR, claims Outcome Improvement Target 4 Estimated Incentive Payment: $260,145
Year 2 Estimated Outcome Amount: $17,674		Year 3 Estimated Outcome Amount: $113,197	Year 4 Estimated Outcome Amount: $195,108	Year 5 Estimated Outcome Amount: $260,145
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $586,124				

Project Title: Expansion of Dallas County dental clinic hours
RHP Project Identifier: 009784201.3.4
Performing Provider: Baylor College of Dentistry / 009784201

Outcome Measure Description:

IT-7.4 -Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period. *(Non-standalone measure)*
Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.

Numerator: Number of children age 0-20 years that have received at least one fluoride varnish application during the measurement period
Denominator: Total number of children age 0-20 years that have been seen by a primary care or dental provider.
Data Source: EHR, Claims
Rationale/Evidence: Children who have regular access to a dental provider are more likely to have received preventive dental services such as fluoride varnish application
Improvement targets are as follows; DY2: 28%, DY3: 29%, DY4: 31% and DY5: 32%.

Rationale:
Approximately 80% of the population seen in the clinics involved in this project includes children age 6-20. Dental sealants are second only to community water fluoridation as an effective preventive strategy for caries. Dental sealants and fluoride varnish are highly effective preventive treatments in young children, and the patient population targeted by the sealant program is children age 6-9, thus outcome measures related to sealants and topical fluoride application are appropriate.

Project metrics will be assessed by collection of oral health surveillance data using the appropriate module of the Basic Screening Survey. Key oral health status indicators relating to project outcome milestones will be captured directly onsite at Dallas elementary school campuses for children enrolled in Kindergarten, second and third grade. Direct data entry will be performed in the school-based sealant program using the SmilesMaker software, a modified version of the CDC's S.E.A.L.S. data collection tool. In both modules of the Basic Screening Survey, the assessment includes age-appropriate oral measures of oral health status including: untreated decay, urgency of care, caries experience, dental sealants and early childhood caries.

Outcome Measure Valuation:

The valuation of this project is based primarily on the value of the care provided by the students during their rotations. The population seen in the clinics is overwhelmingly disadvantaged, underserved and of low socioeconomic status, and will number approximately

10,000 over the four years of the project. Estimating the number students participating annually and their production capacity, we calculate an annual total of 3,300 patient encounters in DY2 and approximately 10,500 each year thereafter. Based on data from non-profit providers in the Dallas area and some of the current externship sites, the average cost of each encounter is approximately $125. A multiplier of 2.7, based on data from The Original National Dental Advisory Service 2012 (Yale Wasserman, D.M.D. Medical Publishers, Ltd. NDAS 30th Edition), will be applied to the average encounter cost. Calculation of this multiplier is based on Medicaid dental reimbursements by procedure code versus the NDAS Comprehensive Fee Report, which is a nationwide marketplace analysis of usual and customary fees. The multiplier is also a way to incorporate the benefit to the community, in terms of addressing a high-priority need, reducing school absences, improving academic performance in children and decreasing workdays lost due to dental complaints, the size of the population served and cost avoidance, as well as the benefit of additional clinical training for the dental students. Altogether, these figures estimate a total of $1M in treatment during the first year of the project, and in excess of $3.6M each year thereafter.

009784201.3.4	*3.IT-7.4*	*Topical Fluoride application: Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period*	
Baylor College of Dentistry		*9784201*	
Related Category 1 or 2 Projects:		*009784201.1.2*	
Starting Point/Baseline:		*50%*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1 Project planning – identify current capacity and needed resources and document implementation plans Milestone 1 Estimated Incentive Payment: $8,837 Outcome Improvement Target 1: IT-7.4 Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period Improvement Target: 28% Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment: $8,837	Outcome Improvement Target 2: IT-7.4 Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period Improvement Target: 29% Data Source: EHR, claims Outcome Improvement Target 2 Estimated Incentive Payment: $113,197	Outcome Improvement Target 3: IT-7.4 Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period Improvement Target: 31% Data Source: EHR, claims Outcome Improvement Target 3 Estimated Incentive Payment: $195,108	Outcome Improvement Target 4: IT-7.4 Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period Improvement Target: 32% Data Source: EHR, claims Outcome Improvement Target 4 Estimated Incentive Payment: $260,145
Year 2 Estimated Outcome Amount: $17,674	Year 3 Estimated Outcome Amount: $113,197	Year 4 Estimated Outcome Amount: $195,108	Year 5 Estimated Outcome Amount: $260,145
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $586,124			

Project Title: Expansion of school-based sealant program
RHP Project Identifier: 009784201.3.5
Performing Provider: Baylor College of Dentistry / 009784201

Outcome Measure Description:

IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal *(Non-standalone measure)*

Numerator: Number of children age 6-9 with a dental sealant on at least one permanent first molar within the measurement period
Denominator: Total number of children age 6-9 that have seen a dental provider within the measurement period
Data Source: EHR, Claims
Rationale/Evidence: Children who have regular access to a dental provider are more likely to have received preventive dental services such as sealant placement.
Improvement targets: DY2: 28%, DY3: 29%, DY4: 31% and DY5: 32%.

Rationale:

The target population for this project will be elementary school students (2nd and 3rd graders) in the Dallas Independent School District and various suburban school districts. More than 80% of DISD children are considered economically disadvantaged, far higher than the state figure of 59%. School campuses with an enrollment of at least 70% economically disadvantaged children will be eligible for participation. According to Basic Screening Survey data collected by the Texas Department of State Health Services in 2008, the last year for which data is available, 34% percent of Texas third-grade children had a sealant on at least one permanent molar tooth. In Dallas County, the figure was 28%. Children enrolled in Texas Medicaid and CHIP as well as those who are not eligible for public insurance will be served through the project. A secondary target population will be the BCD students themselves, who will receive community-based clinical training at the internship sites.

The population seen in the sealant program is children age 6-9. Dental sealants are second only to community water fluoridation as an effective preventive strategy for preventing caries. Dental sealants and fluoride varnish are highly effective preventive treatments in young children, and the patient population targeted by the sealant program is children age 6-9, thus outcome measures related to sealants and topical fluoride application are appropriate.

Project metrics will be assessed by collection of oral health surveillance data using the appropriate module of the Basic Screening Survey. Key oral health status indicators relating to project outcome milestones will be captured directly onsite at Dallas elementary school campuses for children enrolled in Kindergarten, second and third grade. Direct data entry will

be performed in the school-based sealant program using the SmilesMaker software, a modified version of the CDC's S.E.A.L.S. data collection tool. In both modules of the Basic Screening Survey, the assessment includes age-appropriate oral measures of oral health status including: untreated decay, urgency of care, caries experience, dental sealants and early childhood caries.

Outcome Measure Valuation:

The valuation of this project is based primarily on the value of the care provided by the students participating in the school-based sealant program. The population addressed will be second and third grade elementary students in the Dallas and suburban school districts, and over the four years of the project approximately 5,800 additional children will be screened, receive fluoride varnish applications and sealants. Data from the sealant program, collected over the past ten years, indicates that an average of three sealants are placed in each patient encounter, yielding a total of 17,400 additional sealants placed over the four years of the project, relative to baseline. Based on data from non-profit providers and private practitioners in the Dallas, the average fee for sealants is approximately $30 each. For purposes of this valuation, the cost of screenings and fluoride varnish application is not included. A multiplier of six, higher than for restorative treatment, will be applied to the cost of each sealant. The multiplier incorporates the benefit to the community in terms of addressing a high-priority community need, the size of the population served and cost avoidance, e.g. reduced school absences, improved academic performance in children. The cost avoidance, in terms of treatment averted, is particularly high for sealants. Data from studies of the efficacy, cost-effectiveness and cost-benefit of dental preventive intervention estimate that preventing decay on a tooth can avoid restorative treatment that, over a period of as short as ten years, may total as much as $2,800 per tooth, more than 90 times the cost of the sealant. Calculations based on cost, the number of sealants placed annually and the value multiplier estimate a total of $374,220 of care delivered in DY2 and approximately $928,000 each year thereafter.

009784201.3.5	*3.IT-7.1*	*Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth*	
Baylor College of Dentistry		*9784201*	
Related Category 1 or 2 Projects:	*009784201.1.3*		
Starting Point/Baseline:	*28%*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1 Project planning – identify current capacity and needed resources and document implementation plans Milestone 1 Estimated Incentive Payment: $3,118 Outcome Improvement Target 1: IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth Improvement Target: 28% Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment: $3,119	Outcome Improvement Target 2: IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth Improvement Target: 29% Data Source: EHR, claims Outcome Improvement Target 2 Estimated Incentive Payment: $30,942	Outcome Improvement Target 3: IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth Improvement Target: 31% Data Source: EHR, claims Outcome Improvement Target 3 Estimated Incentive Payment: $46,413	Outcome Improvement Target 4: IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth Improvement Target: 32% Data Source: EHR, claims Outcome Improvement Target 4 Estimated Incentive Payment: $61,884
Year 2 Estimated Outcome Amount: $6,237	Year 3 Estimated Outcome Amount: $30,942	Year 4 Estimated Outcome Amount: $46,413	Year 5 Estimated Outcome Amount: $61,884
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $145,476			

Project Title: Expansion of school-based sealant program
RHP Project Identifier: 009784201.3.6
Performing Provider: Baylor College of Dentistry / 009784201

Outcome Measure Description:

IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period. *(Non-standalone measure)* Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - Percentage of children, age 0-6 years, who received a fluoride varnish application during the measurement period.

Numerator: Number of children age 0-6 years that have received at least one fluoride varnish application during the measurement period
Denominator: Total number of children age 0-6 years that have been seen by a primary care or dental provider.
Data Source: EHR, Claims
Rationale/Evidence: Children who have regular access to a dental provider are more likely to have received preventive dental services such as fluoride varnish application.
Improvement targets: DY2: 28%, DY3: 29%, DY4: 31% and DY5: 32%.

Rationale:

The target population for this project will be elementary school students (2nd and 3rd graders) in the Dallas Independent School District and various suburban school districts. More than 80% of DISD children are considered economically disadvantaged, far higher than the state figure of 59%. School campuses with an enrollment of at least 70% economically disadvantaged children will be eligible for participation. According to Basic Screening Survey data collected by the Texas Department of State Health Services in 2008, the last year for which data is available, 34% percent of Texas third-grade children had a sealant on at least one permanent molar tooth. In Dallas County, the figure was 28%. Children enrolled in Texas Medicaid and CHIP as well as those who are not eligible for public insurance will be served through the project. A secondary target population will be the BCD students themselves, who will receive community-based clinical training at the internship sites.

The population seen in the sealant program is children age 6-9. Dental sealants are second only to community water fluoridation as an effective preventive strategy for preventing caries. Dental sealants and fluoride varnish are highly effective preventive treatments in young children, and the patient population targeted by the sealant program is children age 6-9, thus outcome measures related to sealants and topical fluoride application are appropriate.

Project metrics will be assessed by collection of oral health surveillance data using the appropriate module of the Basic Screening Survey. Key oral health status indicators relating to

project outcome milestones will be captured directly onsite at Dallas elementary school campuses for children enrolled in Kindergarten, second and third grade. Direct data entry will be performed in the school-based sealant program using the SmilesMaker software, a modified version of the CDC's S.E.A.L.S. data collection tool. In both modules of the Basic Screening Survey, the assessment includes age-appropriate oral measures of oral health status including: untreated decay, urgency of care, caries experience, dental sealants and early childhood caries.

Outcome Measure Valuation:

The valuation of this project is based primarily on the value of the care provided by the students participating in the school-based sealant program. The population addressed will be second and third grade elementary students in the Dallas and suburban school districts, and over the four years of the project approximately 5,800 additional children will be screened, receive fluoride varnish applications and sealants. Data from the sealant program, collected over the past ten years, indicates that an average of three sealants are placed in each patient encounter, yielding a total of 17,400 additional sealants placed over the four years of the project, relative to baseline. Based on data from non-profit providers and private practitioners in the Dallas, the average fee for sealants is approximately $30 each. For purposes of this valuation, the cost of screenings and fluoride varnish application is not included. A multiplier of six, higher than for restorative treatment, will be applied to the cost of each sealant. The multiplier incorporates the benefit to the community in terms of addressing a high-priority community need, the size of the population served and cost avoidance, e.g. reduced school absences, improved academic performance in children. The cost avoidance, in terms of treatment averted, is particularly high for sealants. Data from studies of the efficacy, cost-effectiveness and cost-benefit of dental preventive intervention estimate that preventing decay on a tooth can avoid restorative treatment that, over a period of as short as ten years, may total as much as $2,800 per tooth, more than 90 times the cost of the sealant. Calculations based on cost, the number of sealants placed annually and the value multiplier estimate a total of $374,220 of care delivered in DY2 and approximately $928,000 each year thereafter.

009784201.3.6	*3.IT-7.3*	*Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period*	
Baylor College of Dentistry		*9784201*	
Related Category 1 or 2 Projects:	*009784201.1.3*		
Starting Point/Baseline:	*28%*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1 Project planning – identify current capacity and needed resources and document implementation plans Milestone 1 Estimated Incentive Payment: $3,118 Outcome Improvement Target 1: IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period Improvement Target: 28% Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment: $3,119	Outcome Improvement Target 2: IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period Improvement Target: 29% Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment: $30,942	Outcome Improvement Target 3: IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period Improvement Target: 31% Data Source: EHR, claims Outcome Improvement Target 3 Estimated Incentive Payment: $46,413	Outcome Improvement Target 4: IT-7.3 Early Childhood Caries (fluoride applications): Percentage of children age 0-6 who received a fluoride varnish application during the measurement period Improvement Target: 32% Data Source: EHR, claims Outcome Improvement Target 4 Estimated Incentive Payment: $61,884
Year 2 Estimated Outcome Amount: $6,237	Year 3 Estimated Outcome Amount: $30,942	Year 4 Estimated Outcome Amount: $46,413	Year 5 Estimated Outcome Amount: $61,884
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $145,476			

Project Title: Expansion of school-based sealant program
RHP Project Identifier: 009784201.3.7
Performing Provider: Baylor College of Dentistry / 009784201

Outcome Measure Description:

IT-7.4 -Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period. *(Non-standalone measure)*
Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.

Numerator: Number of children age 0-20 years that have received at least one fluoride varnish application during the measurement period
Denominator: Total number of children age 0-20 years that have been seen by a primary care or dental provider.
Data Source: EHR, Claims
Rationale/Evidence: Children who have regular access to a dental provider are more likely to have received preventive dental services such as fluoride varnish application
Improvement targets: DY2: 28%, DY3: 29%, DY4: 31% and DY5: 32%.

Rationale:

The target population for this project will be elementary school students (2nd and 3rd graders) in the Dallas Independent School District and various suburban school districts. More than 80% of DISD children are considered economically disadvantaged, far higher than the state figure of 59%. School campuses with an enrollment of at least 70% economically disadvantaged children will be eligible for participation. According to Basic Screening Survey data collected by the Texas Department of State Health Services in 2008, the last year for which data is available, 34% percent of Texas third-grade children had a sealant on at least one permanent molar tooth. In Dallas County, the figure was 28%. Children enrolled in Texas Medicaid and CHIP as well as those who are not eligible for public insurance will be served through the project. A secondary target population will be the BCD students themselves, who will receive community-based clinical training at the internship sites.

The population seen in the sealant program is children age 6-9. Dental sealants are second only to community water fluoridation as an effective preventive strategy for preventing caries. Dental sealants and fluoride varnish are highly effective preventive treatments in young children, and the patient population targeted by the sealant program is children age 6-9, thus outcome measures related to sealants and topical fluoride application are appropriate.

Project metrics will be assessed by collection of oral health surveillance data using the appropriate module of the Basic Screening Survey. Key oral health status indicators relating to

project outcome milestones will be captured directly onsite at Dallas elementary school campuses for children enrolled in Kindergarten, second and third grade. Direct data entry will be performed in the school-based sealant program using the SmilesMaker software, a modified version of the CDC's S.E.A.L.S. data collection tool. In both modules of the Basic Screening Survey, the assessment includes age-appropriate oral measures of oral health status including: untreated decay, urgency of care, caries experience, dental sealants and early childhood caries.

Outcome Measure Valuation:

The valuation of this project is based primarily on the value of the care provided by the students participating in the school-based sealant program. The population addressed will be second and third grade elementary students in the Dallas and suburban school districts, and over the four years of the project approximately 5,800 additional children will be screened, receive fluoride varnish applications and sealants. Data from the sealant program, collected over the past ten years, indicates that an average of three sealants are placed in each patient encounter, yielding a total of 17,400 additional sealants placed over the four years of the project, relative to baseline. Based on data from non-profit providers and private practitioners in the Dallas, the average fee for sealants is approximately $30 each. For purposes of this valuation, the cost of screenings and fluoride varnish application is not included. A multiplier of six, higher than for restorative treatment, will be applied to the cost of each sealant. The multiplier incorporates the benefit to the community in terms of addressing a high-priority community need, the size of the population served and cost avoidance, e.g. reduced school absences, improved academic performance in children. The cost avoidance, in terms of treatment averted, is particularly high for sealants. Data from studies of the efficacy, cost-effectiveness and cost-benefit of dental preventive intervention estimate that preventing decay on a tooth can avoid restorative treatment that, over a period of as short as ten years, may total as much as $2,800 per tooth, more than 90 times the cost of the sealant. Calculations based on cost, the number of sealants placed annually and the value multiplier estimate a total of $374,220 of care delivered in DY2 and approximately $928,000 each year thereafter.

009784201.3.7	*3.IT-7.4*	*Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period*	
Baylor College of Dentistry		*9784201*	
Related Category 1 or 2 Projects:	*009784201.1.3*		
Starting Point/Baseline:	*28%*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1 Project planning – identify current capacity and needed resources and document implementation plans Milestone 1 Estimated Incentive Payment: $3,119 Outcome Improvement Target 1: IT-7.4 Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period Improvement Target: 28% Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment: $3,119	Outcome Improvement Target 2: IT-7.4 Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period Improvement Target: 29% Data Source: EHR, claims Outcome Improvement Target 2 Estimated Incentive Payment: $30,942	Outcome Improvement Target 3: IT-7.4 Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period Improvement Target: 31% Data Source: EHR, claims Outcome Improvement Target 3 Estimated Incentive Payment: $46,413	Outcome Improvement Target 4: IT-7.4 Topical Fluoride application: Percentage of children, age 0-20 years who received a fluoride varnish application during the measurement period Improvement Target: 32% Data Source: EHR, claims Outcome Improvement Target 4 Estimated Incentive Payment: $61,884
Year 2 Estimated Outcome Amount: $6,237	Year 3 Estimated Outcome Amount: $30,942	Year 4 Estimated Outcome Amount: $46,413	Year 5 Estimated Outcome Amount: $61,884
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $145,476			

Title of Outcome Measure (Improvement Target): IT3.3 – Diabetes 30 day readmission rate

Unique RHP outcome identification number: 020908201.3.1

Performing Provider Name/TPI: Texas Health Presbyterian Hospital Dallas/020908201

Outcome Measure Description

IT-3.3 Diabetes 30 day readmission rate (Standalone measure)

- By the end of the waiver, our goal is to decrease 30 day readmission (all causes) for diabetes patients by 15%

- In DY2, we will complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
- In DY3, our goal is to reduce this rate by 4%; to conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress
- In DY4, to reduce diabetes patient readmissions by 10% from baseline, and in DY5 to reduce diabetes patient readmissions by 15% from baseline.

Process Milestones:

- DY2:
    - P-1 Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
    - P-2 Establish baseline rates.
- DY3:
    - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.
    - P-5 Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for each year:

- DY3:
    - IT-3.3 Diabetes 30 day readmission rate (Standalone measure) Improvement Target: 10% improvement from baseline.

- DY4
    - IT-3.3 Diabetes 30 day readmission rate (Standalone measure) Improvement Target: 10% improvement from baseline.
- DY5
    - IT-3.3 Diabetes 30 day readmission rate (Standalone measure) Improvement Target: 15% improvement from baseline.

Rationale

Texas Health Dallas is determined to improve the health and well-being of the community that THD serves and address the needs of the individuals that suffer from diabetes but do not have the means to keep it under control.

THD plans on educating patients that deal with type 1 & 2 diabetes and target specific areas where we can identify how THD is monitoring and managing the care of those individuals by including the following tactics.

- Perform a foot-check on patient
- Check A1C levels
- Assure patient has glucose measurement device & strips
- Ask patient to demonstrate how to use glucose measurement device
- Check to see if patient has medicine for diabetes
- Ask patient to verbalize what medicine they have and how/when to take
- Ask patient about "Sick Day Rule"
- Send patient to diabetes education class

These tactics will help THD verify and quantify how we are striving to improve the health of the community that suffers with diabetes.

Outcome Measure Valuation:

Approach/Methodology: For every inpatient readmission avoided, $8,297 in cost is saved by the healthcare system[593]. Healthcare costs are calculated by multiplying $8297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we

[593] Texas Department of State Health Services with 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

Rationale/Justification: Inpatient readmissions outcome improvement targets are dependent on the target population served (e.g. aging populations will have increased admissions due to higher incidence rates), size (e.g. if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable readmissions (e.g. keeping lower acuity patients under observation instead of admitting them).

020908201.3.1	*3.IT-3.3*	*Diabetes 30 day readmission rate*	
Texas Health Presbyterian Hospital Dallas			*020908201*
Related Category 1 or 2 Projects:	*020908201.1.1*		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of the emergency department with target conditions that do not have access to a primary care physician or medical home **Description of Population:** Community members with target conditions within Region 9, particularly those living in Dallas County		

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ **31,073** **Process Measures Milestone 2** **P-2:** Establish baseline rates Data Source: Hospital discharge records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $ **31,074**	**Milestone 4** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: completion documents Process Milestone 4 Estimated Incentive Payment: $ **172,191** **Milestone 5** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports, communication tools produced to disseminate findings Process Milestone 5 Estimated Incentive Payment: $ **172,191** **Improvement Target 1** [IT-3.3] Diabetes 30 day readmission rate. Improvement Target: 10% improvement from baseline. Data Source: Database determined DY2 Outcome Milestone 1 Estimated Incentive Payment: $ **172,190**	**Improvement Target 2** [IT-3.3] Diabetes 30 day readmission rate Improvement Target: 10% improvement from baseline. Data Source: Identified database determined in DY2 Outcome Milestone 1 Estimated Incentive Payment: $ **105,085**	**Improvement Target 3 [**IT-3.3] Diabetes 30 day readmission rate Improvement Target: 15% improvement from baseline. Data Source: Identified database determined in DY2 Outcome Milestone 1 Estimated Incentive Payment: $ **251,289**

020908201.3.1	*3.IT-3.3*	*Diabetes 30 day readmission rate*	
Texas Health Presbyterian Hospital Dallas			*020908201*
Related Category 1 or 2 Projects:	*020908201.1.1*		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of the emergency department with target conditions that do not have access to a primary care physician or medical home **Description of Population:** Community members with target conditions within Region 9, particularly those living in Dallas County		
Year 2 (10/1/2012 – 9/30/2013)	**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: **$62,147***	Year 3 Estimated Milestone Bundle Amount: **$98,231***	Year 4 Estimated Milestone Bundle Amount: **$105,085***	Year 5 Estimated Milestone Bundle Amount: **$251,289***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $516,752			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Title of Outcome Measure (Improvement Target): IT - 3.10 – Adult Asthma 30 day readmission rate

Unique RHP outcome identification number: 020908201.3.2

Performing Provider Name/TPI: Texas Health Presbyterian Hospital Dallas/020908201

Outcome Measure Description

IT-3.10 Adult Asthma 30 day readmission rate (Standalone measure)

- By the end of the waiver, our goal is to decrease 30 day readmission (all causes) for asthma patients to 8.4%.

- In DY2, we will:
    - Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
- In DY3, our goal is to reduce this rate by 4%; to conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress
- In DY4, to reduce asthma patient readmissions by 10% from baseline, and in DY5 to reduce asthma patient readmissions by 15% from baseline.

Process Milestones:

- DY2:
    - P-1 Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
    - P-2 Establish baseline rates.
- DY3:
    - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.
    - P-5 Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for each year:

- DY3:
    - IT-3.10 Adult Asthma 30 day readmission rate (Standalone measure) Improvement Target: 4% improvement from baseline.
- DY4
    - IT-3. 10 Adult Asthma 30 day readmission rate (Standalone measure) Improvement Target: 10% improvement from baseline.
- DY5
    - IT-3. 10 Adult Asthma 30 day readmission rate (Standalone measure) Improvement Target: 15% improvement from baseline.

Rationale

Texas Health Dallas is determined to improve the health and wellbeing of the community that THD serves and address the needs of the individuals that suffer from asthma but do not have the means to keep it under control.

THD plans on educating patients with asthma and target specific areas where we can identify how THD is monitoring and managing the help of those individuals by including the following tactics.

- Make Peak Flow Monitor available for patient
- Demonstrate to patient how to use Peak Flow
- Have medicine available for patient
- Ask patient to demonstrate how to use an inhaler spacer
- Help patient identify personal asthma triggers
- Make follow up appointment for patient at THD Asthma Clinic.

These tactics will help THD verify and quantify how we are striving to improve the health of the community that suffers with asthma.

Outcome Measure Valuation:

Approach/Methodology: For every inpatient readmission avoided, $6,285 in cost is saved by the healthcare system[594]. Healthcare costs are calculated by multiplying $6,285 by the total

[594] Texas Department of State Health Services with 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

Rationale/Justification: Inpatient readmissions outcome improvement targets are dependent on the target population served (e.g. aging populations will have increased admissions due to higher incidence rates), size (e.g. if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable readmissions (e.g. keeping lower acuity patients under observation instead of admitting them).

020908201.3.2	*3.IT-3.10*	*Adult Asthma 30 day readmission rate*	
Texas Health Presbyterian Hospital Dallas			*020908201*
Related Category 1 or 2 Projects:	*020908201.1.1*		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of the emergency department with target conditions that do not have access to a primary care physician or medical home **Description of Population:** Community members with target conditions within Region 9, particularly those living in Dallas County.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $ **31,073** **Milestone 2 P-2:** Establish baseline rates Data Source: Hospital discharge records Milestone 2 Estimated Incentive Payment *(maximum amount):* $ **31,074**	**Milestone 3** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: completion documents Process Milestone 3 Estimated Incentive Payment: $ **32,744** **Milestone 4** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports, communication tools produced to disseminate findings Process Milestone 4 Estimated Incentive Payment: $ **32,744** **Outcome Improvement Target 1** [IT-3.10] Adult Asthma 30 day readmission rate Improvement Target: Reduce readmission rate by 4% from baseline. Data Source: Database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment: $ **32,743**	**Outcome Improvement Target 2** [IT-3.10] Adult Asthma 30 day readmission rate Improvement Target: Reduce readmission rate to 10.1%. Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment: $ **105,085**	**Outcome Improvement Target 3** [IT-3.10] Adult Asthma 30 day readmission rate Improvement Target: Reduce readmission rate to 8.4%. Data Source: Identified database determined in DY2 Outcome Improvement Target 3 Estimated Incentive Payment: $**251,289**

020908201.3.2	*3.IT-3.10*	*Adult Asthma 30 day readmission rate*	
Texas Health Presbyterian Hospital Dallas			*020908201*
Related Category 1 or 2 Projects:	*020908201.1.1*		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of the emergency department with target conditions that do not have access to a primary care physician or medical home **Description of Population:** Community members with target conditions within Region 9, particularly those living in Dallas County.		
Year 2 (10/1/2012 – 9/30/2013)	**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: **$62, 147***	Year 3 Estimated Milestone Bundle Amount: **$98,231***	Year 4 Estimated Milestone Bundle Amount: **$105,085***	Year 5 Estimated Milestone Bundle Amount: **$251,289***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $516,752			

Title of Outcome Measure (Improvement Target): IT-9.2 – ED Appropriate Utilization

Unique RHP outcome identification number: 020908201.3.3

Performing Provider Name/TPI: Texas Health Presbyterian Hospital Dallas/020908201

Outcome Measure Description

IT-9.2: ED Appropriate Utilization (Stand-alone Measure)

- By the end of the waiver, our goal is to improve appropriate ED utilization for the targeted populations by 18%.
- In DY2, we will:
    - Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
    - Develop and test reporting and monitoring process to evaluate
    - Establish the baseline.
- In DY3, our goal is to reduce this rate by 5%; to conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress
- In DY4, to reduce ED utilization for the targeted populations by 10% from baseline.
- In DY5, to reduce ED utilization for the targeted populations by 18% from baseline.

Process Milestones:

- DY2:
    - P-1 Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
    - P-2 Establish baseline rates.
- DY3:
    - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.
    - P-5 Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for each year:

- DY3
    - IT-9.2: ED Appropriate Utilization Improvement Target: 5% improvement from baseline.
- DY4
    - IT-9.2: ED Appropriate Utilization Improvement Target: 10% improvement from baseline.
- DY5
    - IT-9.2: ED Appropriate Utilization Improvement Target: 18% improvement from baseline.

Rationale

Texas Health Dallas is determined to improve the health and well-being of the community that THD serves and address the needs of the individuals that are affected by the down turn in the economy and do not have sufficient income to manage their own health care.
THD plans on targeting specific areas where we can identify how THD is monitoring and managing the help of those individuals by including the following tactics.

- Allocate physician resources to help manage and educate patients on how to care for their health.
- Identify specific patients that are considered frequent fliers (ED visits 3 or greater in 2012) that are uninsured.
- Utilize EDs facility space in our low acute day center to treat and manage these specific patients on a day to day bases
- Expand THD ED staff to help justify financially the additional FTE's needed to direct patients and manage their health care while not hindering or slowing down the patient flow within in the main ED.
- In 2011, THD ED saw 1,112 uninsured patients with 3 or greater visits, a direct cost of $1,912,345 to THD, average of $1,719 per patient. A monthly average of $159,362.
- From Jan-Aug 2012, THD ED has currently seen 771 uninsured patients with 3 or greater visits, a direct cost of $949,080, average of $1,230 per patient. A monthly average of $118,635.
- The amount of "charity cost" that THD has written off in 2011 ($5,297,373) and in 2012 ($3,879,871) is overwhelming. With focusing our staff and other resources to

care for these patients, addressing their health care needs and set up a manageable health plan to treat and educate the patient while providing a strategy to get these patients on the road to a healthy life.

These tactics will help THD verify and quantify how we are striving to improve the health of the community we serve.

Outcome Measure Valuation

Approach/Methodology: For every ED visit avoided, $411 in cost is saved by the healthcare system.[595] The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

Rationale/Justification: ED visit outcome improvement targets are dependent on the target population served (e.g. the number of frequent flyers, patients with greater than three visits in a year), size (e.g. if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent navigate frequent flyers away from the ED.

Community benefits were calculated using the following factors: lost productivity (net of lost wages), lost in payroll taxes, and lost sales tax. Individual benefits were calculated using the following factors: lost wages, caretaker expense and extension of life (if applicable).

[595] Based on 2011 historical ED visits data for Texas Health Presbyterian Dallas

020908201.3.3	*3.IT-9.2*	*ED appropriate Utilization*	
Texas Health Presbyterian Hospital Dallas			*080908201*
Related Category 1 or 2 Projects:	*020908201.1.1*		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of ED with target conditions who do not have access to PCP or medical home **Description of Population:** Community members with target conditions within Region 9, particularly those living in Dallas County		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $ **31,073** **Milestone 2** [P-2] Establish baseline rates (Emergency Department (ED) visits rate for target population: THD will target unfunded patients with inappropriate ED visits of 3 or greater in 1 calendar year. Baseline: 2012 – 1,407 uninsured patients with 3 or greater ED visits Data Source: Continuing Care Clinic Documents and THD Financial reports (EPSI), EMR – EPIC (CareConnect) Milestone 2 Estimated Incentive	**Milestone 3** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: completion documents Process Milestone 4 Estimated Incentive Payment: $ **32,744** **Milestone 4** [P-5] Disseminate findings, including lessons learned/best practices Data Source: Reports, communication tools produced to disseminate findings Process Milestone 5 Estimated Incentive Payment: $ **32,744** **Outcome Improvement Target 1** [IT-9.2] ED Appropriate Utilization: Improvement Target: 5% improvement from baseline. Data Source: EMR – EPIC (CareConnect , Financial reports (EPSI)	**Outcome Improvement Target 2** [IT-9.2] ED Appropriate Utilization Improvement Target: 10% improvement from baseline. Data Source: Continuing Care Clinic Documents and THD Financial reports (EPSI), EMR – EPIC (CareConnect) Goal: Decrease # of inappropriate ED visits by 10% Outcome Improvement Target 1 Estimated Incentive Payment: $**105,085**	**Outcome Improvement Target 2** [IT-9.2] ED Appropriate Utilization Improvement Target: 18% improvement from baseline. Data Source: Continuing Care Clinic Documents and THD Financial reports (EPSI), EMR – EPIC (CareConnect) Goal: Decrease # of inappropriate ED visits by 18% Outcome Improvement Target 2 Estimated Incentive Payment: $**251,289**

020908201.3.3	*3.IT-9.2*	*ED appropriate Utilization*	
Texas Health Presbyterian Hospital Dallas			*080908201*
Related Category 1 or 2 Projects:	*020908201.1.1*		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of ED with target conditions who do not have access to PCP or medical home **Description of Population:** Community members with target conditions within Region 9, particularly those living in Dallas County		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Payment *(maximum amount):* $ **31,074**	Outcome Improvement Milestone 1 Estimated Incentive Payment: **32,743**		
Year 2 Estimated Milestone Bundle Amount: **$62,147***	Year 3 Estimated Milestone Bundle Amount: **$98,231***	Year 4 Estimated Milestone Bundle Amount: **$105,085***	Year 5 Estimated Milestone Bundle Amount: **$251,289***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $516,752			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Title of Outcome Measure (Improvement Target: 1.7- Controlling High Blood Pressure

Unique RHP outcome identification number (s): 020908201.3.6

Performing Provider Name/TPI: Texas Health Presbyterian Hospital Dallas/020908201

Outcome Measure Description:

IT-1.7 Controlling High Blood Pressure

- **Numerator:** The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg)during the measurement year
- **Denominator:** Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension

Data Source: EHR, Register

Process Milestones:

- DY2:
    - P-1: Establish baseline rates of patients whose most recent BP is adequately controlled <140/90 mm Hg
- DY3:
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection
    - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY4:
    - IT-1.7: Increase number of people 18-75 years old with controlled high blood pressure (<140/90 mm Hg) by 10%.
- DY5:
    - IT-1.7: Increase number of people 18-75 years old with controlled high blood pressure (<140/90 mm Hg) by 15%.

By the end of the waiver, our goal is to increase number of patients 18 – 75 years old with controlled high blood pressure (<140/90 mm Hg) by 15%. Our milestones include the following:

Rationale

Approximately 33% of the US population and Texas has high blood pressure[596] and approximately 50% of this cohort controls their high blood pressure[597]. One of the Healthy People 2020 objectives is to increase the proportion of adults who have their high blood pressure under control[598]. Having high blood pressure can put you at risk for heart disease and stroke, which is the leading cause of death in the United States.[599] However, heart disease is among the most preventable chronic diseases. The leading modifiable (controllable) risk factors for heart disease are: (1) high blood pressure; (2) High blood cholesterol; (3) Cigarette smoking; (4) Diabetes; (5) Poor diet and physical activity and (6) Overweight and obesity.[600] According to the AHRQ rationale, there are multiple studies that have shown that aggressive treatment of high blood pressure can reduce deaths from stroke, heart disease and renal failure.[601] Measuring blood pressure values among patients 18 to 75 years of age with a diagnosis of hypertension identifies those patients who are in poor control and at highest risk for heart disease. We can measure whether evidenced-based self-management programs designed to reduce and control BP <140/90 mm Hg are working, as well as identify the high risk congregants we should target for these programs. In order to get high risk congregants blood pressure levels under control, we will be implementing evidenced-based self-management programs in our Category 2.2 Establishing self-management programs and wellness project so that congregant members with high blood pressure are receiving the knowledge, skills and tools to manage and control their blood pressure.

Achieving the goal of significantly increasing the number of congregants with controlled blood pressure will result in healthier people. As a result of this work, there will be overall improved population health for people with high blood pressure, which reduces the risk of people suffering from debilitating or deadly health complications from heart disease and/or stroke. By establishing evidenced-based self-management programs within the congregational setting people can stay healthy and out of the hospital, which will, in turn, reduce complications from high blood pressure presenting at the emergency room department or being admitted to the hospital.

Outcome Measure Valuation

[596] Centers for Disease Control and Prevention (2012). Hypertension. Retrieved from: http://www.cdc.gov/nchs/fastats/hyprtens.htm
[597] Centers for Disease Control and Prevention (2012). High Blood Pressure Facts. Retrieved from http://www.cdc.gov/bloodpressure/facts.htm
[598] U.S. Department of Health and Human Services (2012). Healthy People.gov [2020 topics and objectives]. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=21
[599] Minino AM., Murphy SL., Xu J., et al. Deaths: Final data for 2008. National Vital Statistics Reports. 2011;Vol 59(10).
[600] U.S. Department of Health and Human Services (2012). Healthy People.gov [2020 topics and objectives]. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=21
[601] U.S. Department of Health and Humans Services (2012). Agency for Healthcare Research and Quality. Retrieved from: http://qualitymeasures.ahrq.gov/content.aspx?id=34655

For every participant, $1,092 in cost is saved by the healthcare system[602]. Healthcare costs are calculated by multiplying $1,092 by the total individuals affected. Outcome improvement targets are dependent on the target population served (e.g. # of participants) and size.

[602] Texas Department of State Health Services with 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

Unique Category 3 ID: *020908201.3.6*	*3.IT-1.7*	*Controlling High Blood Pressure*	
Texas Health Presbyterian Hospital Dallas			*020908201*
Related Category 1 or 2 Projects:	*020908201.2.2*		
Starting Point/Baseline:	*4,000 congregants*		
Year 2 (10/1/2012 – 9/30/2013)	**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]: Establish baseline rates of patients whose most recent BP is adequately controlled <140/90 mm Hg Metric [P-2.1]: Adequately controlled BP (<140/90) Numerator: The number of patients in the denominator whose most recent blood pressure is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. Denominator: Patients 18 to 75 years of age as of December 31 of the measurement year with a diagnosis of hypertension Baseline: 46 out of 67 (68%) had BP lower than 140/90) Data Source: EMR Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $**40,532**	**Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Process Milestone 2 Estimated Incentive Payment: $32,033 **Milestone 3** [P-5]: P- 5: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Process Milestone 3 Estimated Incentive Payment*:* $32,034	**Outcome Improvement Target 1** [IT-1.7]: Controlling high blood pressure Goal: increase number of people 18 – 75 years old with controlled high blood pressure (<140/90 mm Hg) by 10% over baseline. Data Source: EMR – EPIC(CareConnect) Outcome Improvement Target 1 Estimated Incentive Payment*:* $**68,537**	**Outcome Improvement Target 2** [IT-1.7]: Controlling high blood pressure Goal: increase number of people 18 – 75 years old with controlled high blood pressure (<140/90 mm Hg) by 15% over baseline. Data Source: EMR – EPIC(CareConnect) Outcome Improvement Target 2 Estimated Incentive Payment*:* $**163,892**
Year 2 Estimated Outcome Amount: **$40,532***	Year 3 Estimated Outcome Amount: **$64,067***	Year 4 Estimated Outcome Amount: **$68,537***	Year 5 Estimated Outcome Amount: **$163,892***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $337,028			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Title of Outcome Measure (Improvement Target: 1.11- Diabetes care: BP control (<140/80mm Hg)

Unique RHP outcome identification number (s): 020908201.3.7

Performing Provider Name/TPI: Texas Health Presbyterian Hospital Dallas/020908201

Outcome Measure Description:

IT-1.11 Diabetes Care: BP Control (<140/80mm Hg)

- Numerator: Use automated data to identify the most recent blood pressure (BP) reading during measurement year. Member is numerator compliant if BP < 140/90 mm Hg.
- Denominator: Members 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

Process Milestones:

- DY2:
    - P-1: Establish baseline rates of patients whose most recent BP is adequately controlled <140/90 mm Hg
- DY3:
    - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection
    - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY4:
    - IT-1.7: Increase number of people 18-75 years old with controlled high blood pressure (<140/90 mm Hg) by 10%.
- DY5:
    - IT-1.7: Increase number of people 18-75 years old with controlled high blood pressure (<140/90 mm Hg) by 15%.

By the end of the waiver, our goal is to increase number of patients 18 – 75 years old with controlled high blood pressure (<140/90 mm Hg) by 15%. Our milestones include the following:

Rationale

Approximately 33% of the US population and Texas has high blood pressure[603] and approximately 50% of this cohort controls their high blood pressure[604]. One of the Healthy People 2020 objectives is to increase the proportion of adults who have their high blood pressure under control[605]. Having high blood pressure can put you at risk for heart disease and stroke, which is the leading cause of death in the United States.[606] However, heart disease is among the most preventable chronic diseases. The leading modifiable (controllable) risk factors for heart disease are: (1) high blood pressure; (2) High blood cholesterol; (3) Cigarette smoking; (4) Diabetes; (5) Poor diet and physical activity and (6) Overweight and obesity.[607] According to the AHRQ rationale, there are multiple studies that have shown that aggressive treatment of high blood pressure can reduce deaths from stroke, heart disease and renal failure.[608] Measuring blood pressure values among patients 18 to 75 years of age with a diagnosis of hypertension identifies those patients who are in poor control and at highest risk for heart disease. We can measure whether evidenced-based self-management programs designed to reduce and control BP <140/90 mm Hg are working, as well as identify the high risk congregants we should target for these programs. In order to get high risk congregants blood pressure levels under control, we will be implementing evidenced-based self-management programs in our Category 2.2 Establishing self-management programs and wellness project so that congregant members with high blood pressure are receiving the knowledge, skills and tools to manage and control their blood pressure.

Achieving the goal of significantly increasing the number of congregants with controlled blood pressure will result in healthier people. As a result of this work, there will be overall improved population health for people with high blood pressure, which reduces the risk of people suffering from debilitating or deadly health complications from heart disease and/or stroke. By establishing evidenced-based self-management programs within the congregational setting people can stay healthy and out of the hospital, which will, in turn, reduce complications from high blood pressure presenting at the emergency room department or being admitted to the hospital.

Outcome Measure Valuation

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[603] Centers for Disease Control and Prevention (2012). Hypertension. Retrieved from: http://www.cdc.gov/nchs/fastats/hyprtens.htm
[604] Centers for Disease Control and Prevention (2012). High Blood Pressure Facts. Retrieved from http://www.cdc.gov/bloodpressure/facts.htm
[605] U.S. Department of Health and Human Services (2012). Healthy People.gov [2020 topics and objectives]. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=21
[606] Minino AM., Murphy SL., Xu J., et al. Deaths: Final data for 2008. National Vital Statistics Reports. 2011;Vol 59(10).
[607] U.S. Department of Health and Human Services (2012). Healthy People.gov [2020 topics and objectives]. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=21
[608] U.S. Department of Health and Humans Services (2012). Agency for Healthcare Research and Quality. Retrieved from: http://qualitymeasures.ahrq.gov/content.aspx?id=34655

For every participant, $1,092 in cost is saved by the healthcare system[609]. Healthcare costs are calculated by multiplying $1,092 by the total individuals affected. Outcome improvement targets are dependent on the target population served (e.g. # of participants) and size.

[609] Texas Department of State Health Services with 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

Unique Category 3 ID: *020908201.3.7*	*3.IT-1.11*	*Diabetes Care: BP Control*	
Texas Health Presbyterian Hospital Dallas			*020908201*
Related Category 1 or 2 Projects:	*020908201.2.2*		
Starting Point/Baseline:	*4,000 congregants*		
Year 2 (10/1/2012 – 9/30/2013)	**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]: Establish baseline rates of patients whose most recent BP is adequately controlled <140/90 mm Hg Metric [P-2.1]: Adequately controlled BP (<140/90) Numerator: The number of patients in the denominator whose most recent blood pressure is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. Denominator: Patients 18 to 75 years of age as of December 31 of the measurement year with a diagnosis of hypertension Baseline: 46 out of 67 (68%) had BP lower than 140/90), Average A1C value of the 46 patients was 12.4 Data Source: EMR – EPIC (CareConnect) Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $40,532	**Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Process Milestone 2 Estimated Incentive Payment: $32,033 **Milestone 3** [P-5]: P- 5: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Process Milestone 3 Estimated Incentive Payment*:* $32,034	**Outcome Improvement Target 1** [IT-1.7]: Controlling high blood pressure Goal: increase number of people 18 – 75 years old with controlled high blood pressure (<140/90 mm Hg) by 10% over baseline. Data Source: EMR – EPIC (CareConnect) Outcome Improvement Target 1 Estimated Incentive Payment*:* $68,537	**Outcome Improvement Target 2** [IT-1.7]: Controlling high blood pressure Goal: increase number of people 18 – 75 years old with controlled high blood pressure (<140/90 mm Hg) by 15% over baseline. Data Source: EMR – EPIC (CareConnect) Outcome Improvement Target 2 Estimated Incentive Payment*:* $163,892
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):$40,532	Year 3 Estimated Outcome Amount: $64,067	Year 4 Estimated Outcome Amount: $68,537	Year 5 Estimated Outcome Amount: $163,892
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $337,028			

Title of Outcome Measure (Improvement Target): IT-11.5 Addressing Health in Minority Populations: All Cause Readmission Rate for Chronically Ill

Unique outcome identifier: 020908201.3.8

Performing Provider Name/TPI: Texas Health Presbyterian Hospital Dallas 020908201

Outcome Measure Description

The All-Cause Admission Rate for Chronically-Ill patients referred from Texas Health Dallas Presbyterian Hospital to Healing Hands Ministries (HHM) is intended to measure admission rate for chronically ill HHM patients post enrollment. The rate is arrived at using numerator which is the number of all-cause inpatient admissions in one year by patients the denominator - and the denominator which is the number of uninsured patients with a chronic disease (diagnosis of Diabetes, CHF, Hypertension, COPD, or Asthma) referred from hospital to HHM who have been enrolled in the HHM program at least one year. By the end of DY2, the All-Cause Admission rate for chronically ill patients' milestone baseline will be established. The admission rate improvement for DY3, DY4 and DY5 will be 5%, 7% and 10% under baseline respectively.

Rationale

As indicated in the Dallas Fort Worth Hospital Council's RHP 9 Community Needs Assessment, an analysis of the emergency department encounters demonstrates that many in the population are accessing emergency departments for both urgent and non-urgent conditions. Emergency room encounters that result in an in-patient admission tend to be more complex in nature and based on the data, the most frequent conditions that lead to admissions were: stroke, congestive heart failure, weak/failing kidneys, heart attack, and chronic bronchitis. There is a correlation between hospitalization for chronically-ill patients and access to primary care. Timely and effective primary care could reduce the risk of hospitalizations due to ambulatory care sensitive conditions. Therefore, the All-Cause Admission rate for MMH patients demonstrates one of the benefits of connecting a patient to a patient centered medical home. As stated by Bindman and others), "at a community level there is a strong positive association between health care access and preventable hospitalization rates."[610]

Outcome Measure Valuation

Approach/Methodology: For every inpatient readmission avoided, $7,724 in cost is saved by the healthcare system[611]. Healthcare costs are calculated by multiplying $7,724 by the total

[610] Bindman AB, Grumbach K, Osmond D, et al. Preventable Hospitalizations and Acess to Health Care. The Journal of the American Medical Association.1995;274(4):305-311.

[611] Based on the average avoided inpatient admission cost for Diabetes, CHF, Hypertension, COPD, or Asthma, and assumes a cost-to-revenue of 30%. Texas Department of State Health Services.

individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

Rationale/Justification: Inpatient readmissions outcome improvement targets are dependent on the target population served (e.g. aging populations will have increased admissions due to higher incidence rates), size (e.g. if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable readmissions (e.g. keeping lower acuity patients under observation instead of admitting them).

020908201.3.8	IT-11.5	Addressing Health in Minority Populations: All Cause Readmission Rate for Chronically Ill	
Texas Health Presbyterian Hospital Dallas			*020908201*
Related Category 1 or 2 Projects:	*020908201.2.3*		
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)**
Milestone 1 [P-2]: Establish and document baseline for new HHM patient admissions per patient per yr Metric: Completed baseline for all-cause admission rate for chronically-ill patients referred from THD to Healing Hands Data Source: admissions data from hospital database Numerator: number of all-cause inpatient admissions in one year by patients in the denominator. Denominator: number of uninsured patients with a chronic disease(diagnosis of Diabetes, CHR, Hypertension, COPD, or Asthma) referred from hospital to HHM who have been enrolled in the HHM program at least one year Process Milestone 1 Estimated Incentive Payment: $179,099	**Outcome Improvement Target 1** [IT-1.10]: Goal: Achieve an admission rate 5% lower than baseline for patients enrolled at least one year at HHM Data Source: admissions data from hospital database Outcome Improvement Target 1 Estimated Incentive Payment*:* **$283,090**	**Outcome Improvement Target 2** [IT-1.10]: Goal: Achieve an admission rate approximately 7% lower than baseline for patients enrolled at least one year in HHM Data Source: admissions data from hospital database Outcome Improvement Target 2 Estimated Incentive Payment*:* **$302,841**	**Outcome Improvement Target 3** [IT-1.10]: Goal Achieve an admission rate approximately 10% lower than baseline) for patients enrolled at least one year in HHM Data Source: admissions data from hospital database Outcome Improvement Target 3 Estimated Incentive Payment*:* **$724,184**
Year 2 Estimated Outcome Amount: **$179,099***	Year 3 Estimated Outcome Amount: **$283,090***	Year 4 Estimated Outcome Amount: **$302,841***	Year 5 Estimated Outcome Amount: **$724,184***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,489,214			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Title of Outcome Measure (Improvement Target): IT-5.1 - Cost of Care

Unique outcome identifier: 020908201.3.9

Performing Provider Name/TPI: Texas Health Presbyterian Hospital Dallas 020908201

Outcome Measure Description

IT-5.1: Cost of Care: Cost Benefit Analysis of new enrollees in Healing Hands Ministries (HHM).

Process Milestones:

DY2:

- P-1 Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- P-2 Establish baseline rates.

DY3:

- P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.
- P-5 Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for each year:

- DY4
    - IT-5.1: Increase patient enrollment: 15% improvement from DY3.
- DY5
    - IT-5.1: Increase patient enrollment: 15% improvement from DY4.

Rationale

As indicated in the Dallas Fort Worth Hospital Council's RHP 9 Community Needs Assessment, an analysis of the emergency department encounters demonstrates that many in the population are accessing emergency departments for both urgent and non-urgent conditions. Emergency room encounters that result in an in-patient admission tend to be more complex in

nature and based on the data, the most frequent conditions that lead to admissions were: stroke, congestive heart failure, weak/failing kidneys, heart attack, and chronic bronchitis. There is a correlation between hospitalization for chronically-ill patients and access to primary care. Timely and effective primary care could reduce the risk of hospitalizations due to ambulatory care sensitive conditions. Lack of primary care and over utilization of the ED leads to increased cost.

- In 2011, THD ED saw 1,112 uninsured patients with 3 or greater visits, a direct cost of $1,912,345 to THD, average of $1,719 per patient. A monthly average of $159,362.
- From Jan-Aug 2012, THD ED has currently seen 771 uninsured patients with 3 or greater visits, a direct cost of $949,080, average of $1,230 per patient. A monthly average of $118,635.
- The amount of "charity cost" that THD has written off in 2011 ($5,297,373) and in 2012 ($3,879,871) is overwhelming. With focusing our staff and other resources to care for these patients, addressing their health care needs and set up a manageable health plan to treat and educate the patient while providing a strategy to get these patients on the road to a healthy life.

Texas Health Dallas Presbyterian Hospital donates $845 services provided per HHM enrollee/year, and a recent study[612] shows that enrolled patients reduce healthcare costs average ~$2,300 per patient/year. Based on this statistic, we estimated the cost benefit savings = $2,300 - $845 = $1,455 per HHM enrollee/ year.

Outcome Measure Valuation:

Approach/Methodology: For every enrollee, $1,455 in cost is saved by the healthcare system per year.1,2 Healthcare costs are calculated by multiplying $1,455 by the total number of enrollees. There are no direct individual or community savings being calculated for this outcome.

Rationale/Justification: Outcome improvement targets are dependent on the target population served (e.g. the number of new enrollees each year).

[612] http://www.hfma.org/Forums/Forums/CFO/Calculating-ROI-of-Clinics-Targeting-Low-Income-Patients/

020908201.3.9	*IT-5.1*	*Per episode Cost of Care*	
Texas Health Presbyterian Hospital Dallas			*020908201*
Related Category 1 or 2 Projects:	*020908201.2.3*		
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)**
Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity/needed resources, determine timelines, document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment: $89,549 **Milestone 2** [P-2]: Establish baseline rates (Emergency Department (ED) visits rate for target population: THD will target unfunded patients with inappropriate ED visits of 3 or greater in 1 calendar year. Data Source: Continuing Care Clinic Documents and THD Financial reports Milestone 2 Payment: $89,550	**Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 3 Estimated Incentive Payment: $ ***141,545*** **Milestone 4** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Milestone 4 Estimated Incentive Payment: $ 141,545	**Outcome Improvement Target 1** [IT-5.1]: Increase enrollment of HHM to reduce healthcare cost Data Source: Internal database Goal: Increase number of new enrollees by 15% over DY3 Outcome Improvement Target 1 Estimated Incentive Payment: $302,841	**Outcome Improvement Target 2** [IT-5.1]: Increase enrollment of HHM to reduce healthcare cost Data Source: Internal database Goal: Increase number of new enrollees by 15% over DY4 Outcome Improvement Target 2 Estimated Incentive Payment: $724,184
Year 2 Estimated Outcome Amount: **$179,099***	Year 3 Estimated Outcome Amount: **$283,090***	Year 4 Estimated Outcome Amount: **$302,841***	Year 5 Estimated Outcome Amount: **$724,184***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,489,214			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Title of Outcome Measure (Improvement Target): IT-9.2: ED Appropriate Utilization

Unique RHP Outcome Identification Number: 020967801.3.1

Performing Provider Name/TPI: Texas Health Presbyterian Hospital Denton/020967801

Outcome Measure Description

IT-9.2 ED Appropriate Utilization

- By the end of the waiver, our goal is to improve appropriate ED utilization for the targeted populations by 18%.
- In DY2, we will:
    - Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
    - Develop and test reporting and monitoring process to evaluate
    - Establish the baseline.
- In DY3, our goal is to conduct performance improvement projects to work towards reductions and disseminate information to key stakeholders regarding our progress
- In DY4, to reduce ED utilization for the targeted populations by 9% from baseline.
- In DY5, to reduce ED utilization for the targeted populations by 18% from baseline

Process Milestones:

- DY2:
    - P-1 Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
    - P-2 Establish baseline rates.
- DY3:
    - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.
    - P-5 Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for each year:

- DY4
    - IT-9.2: ED Appropriate Utilization Improvement Target: 9% improvement from baseline.
- DY5
    - IT-9.2: ED Appropriate Utilization Improvement Target: 18% improvement from baseline.

Rationale

Utilization of the Texas Health Presbyterian Hospital Denton's Emergency Department has been steadily increasing over the last several years with an 8.08% increase in ED patient volume between 2010 (35050 visits) and 2011 (37833 visits). Estimates for 2012 (42734 visits) indicate an additional 12.8% increase in volume will be noted from 2011 to 2012. 49.61% of the patients currently utilizing our ED are unfunded or Medicaid funded patients increasing from 46.89% in 2010, many of whom routinely use the ED for management of their chronic condition or episodic care. Baseline data regarding an active relationship with a PCP for this population is not known at this time. Frequent users of the ED for episodic care are comprised of a variety of diagnoses.

This program provides patients utilizing the ED for non-emergent care needs with a resource (ED-based nurse navigator) to help navigate them to appropriate resources.
The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much focus in DY2 will be on the finalization of plans and implementation of a process for hiring and training staff, identifying individuals who are frequent users of the ED or who are utilizing the ED for services that might be provided at a lower level of care, and organizing a process to navigate the individuals to more appropriate health care venues. In DY2, we will also develop a mechanism for 1) tracking patients, 2) identifying referral resources, and (3) monitoring the effectiveness of interventions Utilization of improvement methodologies such as Plan-Do-Study-Act to identify and test processes for incremental improvements in processes and outcomes will be incorporated throughout the waiver period. Additionally, active dissemination of findings and lessons learned from the learning collaborative, as well as, best practices found in the literature will occur with stakeholders. DY 4 and 5, will continue to monitor our effectiveness and take action to improve performance as needs are identified

Outcome Measure Valuation

Approach/Methodology: For every ED visit avoided, $421 in cost is saved by the healthcare system.[613] The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

Rationale/Justification: ED visit outcome improvement targets are dependent on the target population served (e.g. the number of frequent flyers, patients with greater than three visits in a year), size (e.g. if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent navigate frequent flyers away from the ED.

Community benefits were calculated using the following factors: lost productivity (net of lost wages), lost in payroll taxes, and lost sales tax. Individual benefits were calculated using the following factors: lost wages, caretaker expense and extension of life (if applicable).

[613] Based on 2011 historical ED visits data for Texas Health Presbyterian Denton

90267801.3.1	*IT-9.2*	*ED Appropriate Utilization*	
Texas Health Presbyterian Hospital Denton			*02967801*
Related Category 1 or 2 Projects::	*020967801.2.1*		
Starting Point/Baseline:	*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)**
Milestone 1[P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ **31,628** **Milestone 2** [P-2]: Establish baseline rates (Emergency Department (ED) visits rate for target population: Congestive Heart Failure, Diabetes, End Stage Renal Disease, Cardiovascular Disease/Hypertension, Behavioral Health/Substance Abuse, Chronic Obstructive Pulmonary Disease and Asthma patients; others TBD) Data Source: Hospital discharge records Milestone 2 Estimated Incentive Payment *(maximum amount):* $**31,628**	**Milestone 4** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: $ **49,992** **Milestone 5** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Milestone 5 Estimated Incentive Payment: $ **49,992** **Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization (**Standalone measure**) Improvement Target: 1% improvement from baseline as systems and processes are defined.	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate Utilization Improvement Target: 9% improvement from baseline. Data Source: Hospital discharge records Outcome Improvement Target 2 Estimated Incentive Payment: $**160,440**	**Outcome Improvement Target 3** [IT-9.2]: ED Appropriate Utilization Improvement Target: 18% improvement from baseline. Data Source: Hospital discharge records Outcome Improvement Target 3 Estimated Incentive Payment: $**383,662**

90267801.3.1	*IT-9.2*	*ED Appropriate Utilization*	
Texas Health Presbyterian Hospital Denton			*02967801*
Related Category 1 or 2 Projects::	*020967801.2.1*		
Starting Point/Baseline:	*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)**
Milestone 3:[P- 3]: Develop and test data systems Data Source: Internally developed database using EMR, coding and/or case management data to monitor project and produce reports. Milestone 3 Estimated Incentive Payment: $**31,628**	Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment: $ **49,993**		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): **$94,884***	Year 3 Estimated Outcome Amount: **$149,977***	Year 4 Estimated Outcome Amount: **$160,440***	Year 5 Estimated Outcome Amount: **$383,662***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $788,963			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Title of Outcome Measure (Improvement Target): 1.10 Diabetes Care: HbA1c Poor Control (>9.0%)

Unique RHP outcome identification number: 020967801.3.2

Performing Provider Name/TPI: Texas Health Presbyterian Hospital Denton/020967801.3.2

Outcome Measure Description

IT-1.10 Diabetes Care: HbA1c Poor control (>9.0%)

- Decrease the Number of diabetes clinic participants whose HbA1C is >9.0 by 15%

Process Milestones:

- DY2:
    - P-1 Project planning, engage stake holders, identify current capacity and needed resources, determine timelines and document implementation plans.
    - P-2 Establish baseline rates.
    - P-3 Develop and test data systems, Data source: Internally
- DY3:
    - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.
    - P-5 Disseminate findings, including lessons learned and best practices to stakeholders.
        - In DY3, our goal is to reduce this rate by four (4) percent.

Outcome Improvement Targets for each year:
By the end of the waiver, our goal is to improve the health of diabetes patients whose Hba1c is >9.0 by 15% or 300 patients.

- DY3:
    - HbA1c is >9.0 by 10 percent from baseline. 1IT- 3.2 Diabetes care: HbA1c
- DY4
    - 2IT-1.10 Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0. More specific, In DY4, the goal is to reduce the number of patients with diabetes whose HbA1c is >9.0 by 10 percent from baseline.

- DY5
    - 3IT-1.10 –Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1C >9.0. More specific, In DY4, the goal is to reduce the number of patients with diabetes whose HbA1c is >9.0 by 15 percent from baseline.

Rationale

The goal of this project is to develop and implement a more comprehensive diabetes education, self management, identify a medical home and reduce 30-Day readmissions caused by uncontrolled diabetes among the under served within our community. Our goal is to improve health outcomes and diabetes self management competency of the resident of Denton County. In doing so, our facility will form a multidisciplinary team, including a certified diabetes educator, clinical navigator, pharmacists, dieticians, physicians, and nurses that will manage the Wagner Chronic Care Clinic model to assist patients with the management of their diabetes.

Currently, the THDN ED provides an exemplary level of care to a diverse population. In order to prevent diabetes complications, patients need an alternative toward using the ED for primary care. We have selected this project to reduce complications associated with diabetes, reduce ED visits and readmissions, and improve the quality of life for this diverse populous.

Denton County is one of the fastest-growing counties in the U.S. As of the 2010 census, its population was 662,614, which is a 41.4% increase in population between the years 2000-2007. The demographics of the county was 75% White, 8.4% Black or African American, 0.7% Native American, 6.6% Asian, 0.1% Pacific Islander, and 2.9% from two or more races. 18.2% of the population was of Hispanic or Latino origin.

According to the US Department of Health and Human Services 2007 Report the Denton County population consists of 4.6% diabetics, 23.3% obese, 17.3% high blood pressure, 16.2% use tobacco, 22.2% do not exercise and 80.1% consume few fruits and vegetables. The THDN ED, alone, has experienced significant growth over the last three years.

YTD as of 9/2012 ER Visits = 32,132
2011 – ER Visits = 37,883
2010 – ER Visits – 35,050

Currently, there is not a consistent method for identifying diabetics who present in the ED, which results in variability of care for the underserved. Some of these patients have not been effectively educated on how to manage their diabetes and/or understand their daily regimen and need for monitoring of their disease process. This gap has created a lack of understanding for their long-term goals.

This program is designed to help those in need of education on managing chronic diabetes patients by providing education and disease management services. In turn, it will also reduce

the number of 30-day readmissions. Patients will be identified by: first, partnering with primary care clinicians to utilize protocols: A1C>9, history of DKA, > one admission in the last 12 months as criteria for referrals to outpatient diabetes education. Second, ED case management and inpatient diabetes educator will identify patients with the same criteria as above, help identify a patient centered medical home for diabetics that have not received diabetes education ever or within the last five years, and provide education for others as needed and within the community.

As a result, we have calculated the following targets:

IP Admissions DY2 649	IP Admissions in DY3 681	IP Admission DY4 715
Readmission rate 16%	Readmission rate 16%	Readmission 16%
Readmit Reduction 0	Readmit Reduction 3%	Readmit Reduction 6%

By DY5, THDN would reduce the readmission rate by 15% based on 751 admissions and a 16% readmit rate. In DY3, DY4 and DY5, we will continue to monitor our effectiveness and take the necessary steps to improve performance.

Outcome Measure Valuation:

Approach/Methodology: For every inpatient admission avoided, $8297 in cost is saved by the healthcare system.[614] Healthcare costs are calculated by multiplying $8297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

Rationale/Justification: Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g. if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g. keeping lower acuity patients under observation instead of admitting them).

Community benefits were calculated using the following factors: lost productivity (net of lost wages), work preseentism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using the following factors: lost wages, caretaker expense and extension of life (if applicable).

[614] Based on 2011 historical inpatient diabetes admissions data for Texas Health Arlington Memorial

020967801.3.2	*IT-1.10*	*Diabetes Care: HbA1c Poor control (>9.0%)*	
Texas Health Presbyterian Hospital Denton			*020967801*
Related Category 1 or 2 Projects:	*020967801.2.2*		
Starting Point/Baseline:	*Estimated diabetes 30 day readmission rate is at 19% Baseline will be confirmed 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)**
Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $ **5,896** **Milestone 2** [P- 2]: Establish baseline rates Data Source: EMR, laboratory data Milestone 2 Estimated Incentive Payment *(maximum amount):* **$ 5,896** **Milestone 3** [P-3]:Develop and test data systems Data Source: Internally developed database using EMR clinic data to monitor project and produce reports. Milestone 3 Estimated Incentive Payment: $**5,896**	**Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: completion documents Milestone 4 Estimated Incentive Payment: $**9,320** **Milestone 5** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports, communication tools produced to disseminate findings Milestone 5 Estimated Incentive Payment: $**9,320** **Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0 Goal: 4%reduction from baseline. Data Source: Database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment*:* $**9,320**	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0 Goal: 10% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment*:* $29,912	**Outcome Improvement Target 3** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0 Goal: 15% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 3 Estimated Incentive Payment*:* $71,528

020967801.3.2	*IT-1.10*	*Diabetes Care: HbA1c Poor control (>9.0%)*	
Texas Health Presbyterian Hospital Denton			*020967801*
Related Category 1 or 2 Projects:	*020967801.2.2*		
Starting Point/Baseline:	*Estimated diabetes 30 day readmission rate is at 19% Baseline will be confirmed 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)**
Year 2 Estimated Outcome Amount: $17,690*	Year 3 Estimated Outcome Amount: $27,962*	Year 4 Estimated Outcome Amount: $29,912*	Year 5 Estimated Outcome Amount: $71,528*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $147,092			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Title of Outcome Measure (Improvement Target): 9.2 ED Appropriate Utilization

Unique RHP outcome identification number: 094140302.3.1

Performing Provider Name/TPI: Texas Health Presbyterian Hospital Kaufman/094140302

Outcome Measure Description

IT-9.2 ED Appropriate Utilization

- By the end of the waiver, our goal is to improve appropriate ED utilization for the targeted populations by 18%.
- In DY2, we will:
    - Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
    - Develop and test reporting and monitoring process to evaluate
    - Establish the baseline.
- In DY3, our goal is to reduce this rate by 18%; to conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress
- In DY4, to reduce ED utilization for the targeted populations by 18% from baseline.

In DY5, to reduce ED utilization for the targeted populations by 18% from baseline

Process Milestones

- DY2:
    - P-1 Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
    - P-2 Establish baseline rates.
- DY3:
    - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

- P-5 Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for each year:

- DY4
  - IT-9.2: ED Appropriate Utilization Improvement Target: 18% improvement from baseline.
- DY5
  - IT-9.2: ED Appropriate Utilization Improvement Target: 18% improvement from baseline.

Rationale

It is anticipated that this program patients utilizing the ED for non-emergent care or repetitive chronic care needs with a culturally competent ED-based nurse navigator to help connect them to appropriate resources and consistent clinical care. Utilization of the emergency department for management of chronic disease or for episodic care results in higher health care costs and less effective management of chronic health conditions or disease prevention. Through the implementation of this program, the ED nurse navigator can connect the patients without an established PCP to a healthcare provider, assist in coordination of service amongst specialties, connect the patient to appropriate community resources (financial, transportation, child care, medication support, translation/interpretation services, etc.), provide necessary education for improved self-management skills and assist patients in complying with follow-up care to improve their health and prevent utilization of more costly resources (such as the emergency department or hospital). Additionally, this specific role can learn from others or share lessons learned with others in the learning collaborative related to this state-wide initiative to improve related outcomes

Approach/Methodology: For every ED visit avoided, $421 in cost is saved by the healthcare system.[615] The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

Rationale/Justification: ED visit outcome improvement targets are dependent on the target population served (e.g. the number of frequent flyers, patients with greater than three visits in

[615] Based on 2011 historical ED visits data for Texas Health Presbyterian Kaufman

a year), size (e.g. if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent navigate frequent flyers away from the ED.

Community benefits were calculated using the following factors: lost productivity (net of lost wages), lost in payroll taxes, and lost sales tax. Individual benefits were calculated using the following factors: lost wages, caretaker expense and extension of life (if applicable).

094140302.3.1	*IT-9.2*	*Right Care, Right Setting IT-9.2 ED Appropriate Utilization*	
Texas Health Presbyterian Hospital Kaufman			*094140302*
Related Category 1 or 2 Projects:	*094140302.2.1 Patient Navigation Program - ED Navigator*		
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)**
Milestone 1[P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $25,362 **Milestone 2** [P-2]: Establish baseline rates (Emergency Department (ED) visits rate for target population: Congestive Heart Failure, Diabetes, End Stage Renal Disease, Cardiovascular Disease/Hypertension, Behavioral Health/Substance Abuse, Chronic Obstructive Pulmonary Disease and Asthma patients; others TBD) Data Source: Hospital discharge records Milestone 2 Estimated Incentive Payment *(maximum amount):* $**25,362** **Milestone 3**:[P- 3]: Develop and test data systems	**Milestone 4** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: $ **40,089** **Milestone 5** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Milestone 5 Estimated Incentive Payment: $ **40,089** **Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization (**Standalone measure**) Improvement Target: 1% improvement from baseline as systems and processes are defined.	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate Utilization Improvement Target: 9% improvement from baseline. Data Source: Hospital discharge records Outcome Improvement Target 2 Estimated Incentive Payment: $ 128,657	**Outcome Improvement Target 3** [IT-9.2]: ED Appropriate Utilization Improvement Target: 18% improvement from baseline. Data Source: Hospital discharge records Outcome Improvement Target 3 Estimated Incentive Payment: $ 307,659

094140302.3.1	*IT-9.2*	*Right Care, Right Setting IT-9.2 ED Appropriate Utilization*	
Texas Health Presbyterian Hospital Kaufman			*094140302*
Related Category 1 or 2 Projects:	*094140302.2.1 Patient Navigation Program - ED Navigator*		
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)**
Data Source: Internally developed database using EMR, coding and/or case management data to monitor project and produce reports. Milestone 3 Estimated Incentive Payment: $**25,363**	Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment: $ **40,090**		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $76,088*	Year 3 Estimated Milestone Bundle Amount: $120,266*	Year 4 Estimated Milestone Bundle Amount: $128,657*	Year 5 Estimated Milestone Bundle Amount: $307,659*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $632,670			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**

Title of Outcome Measure (Improvement Target): IT-1.10: Diabetes Care: HbA1c Poor Control (>9.0%)

Unique RHP outcome identification number: 094140302.3.2

Performing Provider Name/TPI: Texas Health Presbyterian Hospital Kaufman/094140302

Outcome Measure Description

IT-1.10 Diabetes Care: HbA1c Poor control (>9.0%)

- Decrease the Number of diabetes clinic participants whose HbA1C is >9.0 by 15%

Process Milestones

- DY2:
    - P-1 Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
    - P-2 Establish baseline rates.
    - P-3 Develop and test data systems, Data source: Internally
- DY3:
    - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.
    - P-5 Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement Targets for each year

- DY3:
    - 1IT- 3.2 Diabetes care: HbA1c
- DY4
    - 2IT-1.10 Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0

- DY5
    - 3IT-1.10 –Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1C >9.0

Rationale

The goal of this project is to develop and implement a more comprehensive diabetes education center/medical home to help reduce the rates of uncontrolled diabetes among project participants.

Our goal is to improve the health outcomes and diabetes self-management competency of community residents in Kaufman County THK data indicates that Medicaid and uninsured patients make up about 31% of our payer mix of those treated and released from the ED and approximately 28.05% of inpatient population.

In our service area the Hispanic community makes up approximately 18% of the population and is the fastest growing ethnicity in Kaufman County. Hispanic people are about 1.5 times more likely to develop diabetes than non-Hispanic white people.

In the current THK Outpatient Diabetes Education Program, approximately 75% of those served are Caucasian, thus indicating a need for innovation and creativity to reach this population. By developing a comprehensive diabetes clinic available to unfunded or government-funded members in the community, individuals previously struggling to obtain medical care will have access to the care they need to more effectively manage their diabetes.

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much focus in DY2 will be on the finalization of plans and implementation of an outpatient nurse-practitioner run diabetes clinic, expanding on the existing diabetes self-management education service currently provided to our patients. In DY2, we will also develop a mechanism for identifying and tracking high-risk diabetic patients and monitoring effectiveness of interventions (enhanced education, self-management coaching, closer monitoring of medical condition, post-discharge telephonic case management,…) to begin analysis of our information and determine potential improvement opportunities.

- In DY3, performance improvement initiatives will be implemented based on opportunities identified and a reporting mechanism developed to disseminate information regarding project

- In DY 4 and 5, we will continue to monitor our effectiveness and take action to improve performance as needs are identified

Outcome Measure Valuation

Approach/Methodology: For every inpatient admission avoided, $8297 in cost is saved by the healthcare system.[616] Healthcare costs are calculated by multiplying $8297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

Rationale/Justification: Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g. if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g. keeping lower acuity patients under observation instead of admitting them).

Community benefits were calculated using the following factors: lost productivity (net of lost wages), work preseentism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using the following factors: lost wages, caretaker expense and extension of life (if applicable).

[616] Based on 2011 historical inpatient diabetes admissions data for Texas Health Arlington Memorial

094140302.3.2	*3.IT-1.10*	*Diabetes Care: HbA1c Poor control (>9.0%)*	
Texas Health Presbyterian Hospital Kaufman			*094140302*
Related Category 1 or 2 Projects:	*094140302.2.2*		
Starting Point/Baseline:	*Estimated diabetes 30 day readmission rate is at 19% Baseline will be confirmed 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)**
Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Implementation plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 852 **Milestone 2** [P- 2]: Establish baseline rates Data Source: EMR, laboratory data Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 852 **Milestone 3** [P-3]:Develop and test data systems Data Source: Internally developed database using EMR clinic data to monitor project and produce reports. Milestone 3 Estimated Incentive Payment: $851	**Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: complesion documents Milestone 4 Estimated Incentive Payment: $ **1,346** **Milestone 5** [P- 5]: Disseminate findings, lessons learned/best practices, to stakeholders Data Source: Reports or other communication Milestone 5 Estimated Incentive Payment: $1,346 **Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0 Goal: 4%reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment*:* $ **1,346**	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0 Goal: 10% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment*:* $4,319	**Outcome Improvement Target 3** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0 Goal: 15% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 3 Estimated Incentive Payment*:* $10,329
Year 2 Estimated Milestone Bundle Amount: $2,555*	Year 3 Estimated Milestone Bundle Amount: $4,038*	Year 4 Estimated Milestone Bundle Amount: $4,319*	Year 5 Estimated Milestone Bundle Amount: $10,329*

094140302.3.2	*3.IT-1.10*	*Diabetes Care: HbA1c Poor control (>9.0%)*	
Texas Health Presbyterian Hospital Kaufman			*094140302*
Related Category 1 or 2 Projects:	*094140302.2.2*		
Starting Point/Baseline:	*Estimated diabetes 30 day readmission rate is at 19% Baseline will be confirmed 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*:* $21,241			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**
Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Title of Outcome Measure (Improvement Target): IT-3.3 Diabetes 30-day Readmission Rate

Unique RHP outcome identification number: 094140302.3.3

Performing Provider Name/TPI: Texas Health Presbyterian Hospital Kaufman/094140302

Outcome Measure Description

IT-3.3 Diabetes 30 Day Readmission Rate

- Rate 1: Number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission.

Process Milestones:

- DY2:
    - P-1 Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
    - P-2 Establish baseline rates.
    - P-3 Develop and test data systems, Data source: Internally
- DY3:
    - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.
    - P-5 Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets for each year:

- DY3:
    - 1IT- 3.2 Diabetes 30 day readmission rate (Standalone Measure) Improvement Target: 4% reduction from baseline
- DY4
    - IT-3.2 Diabetes 30 day readmission rate (Standalone measure) Improvement Target: 10% reduction from baseline.
- DY5
    - 1T-3.2 Diabetes 30 day readmission rate (Standalone measure) Improvement Target: 15% reduction from baseline

Rationale

The goal of this project is to develop and implement a more comprehensive diabetes education center/medical home to help reduce the rates of uncontrolled diabetes among project participants. Our goal is to improve the health outcomes and diabetes self-management competency of community residents in Kaufman County According to internal data, diabetes was the fourth highest readmission rate at THK from August 2011 – July 2012 this indicates a 30 readmission rate of over 19%. Additionally, 10% of the THK service area has been diagnosed with diabetes. Based on THK outpatient diabetes education data, the program is underutilized in comparison with the service area diabetic population. Our proposed intervention will help individuals who are traditionally underserved and give them access to diabetes education and regular clinical care so they can better manage their diabetes and prevent hospital readmissions.

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much focus in DY2 will be on the finalization of plans and implementation of an outpatient nurse-practitioner run diabetes clinic, expanding on the existing diabetes self-management education service currently provided to our patients. In DY2, we will also develop a mechanism for identifying and tracking high-risk diabetic patients and monitoring effectiveness of interventions (enhanced education, self-management coaching, closer monitoring of medical condition, post-discharge telephonic case management,…) to begin analysis of our information and determine potential improvement opportunities.
In DY3, performance improvement initiatives will be implemented based on opportunities identified and a reporting mechanism developed to disseminate information regarding project. In DY 4 and 5, we will continue to monitor our effectiveness and take action to improve performance as needs are identified.

Outcome Measure Valuation:

Approach/Methodology: For every inpatient admission avoided, $8297 in cost is saved by the healthcare system.[617] Healthcare costs are calculated by multiplying $8297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

[617] Based on 2011 historical inpatient diabetes admissions data for Texas Health Arlington Memorial

Rationale/Justification: Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g. if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g. keeping lower acuity patients under observation instead of admitting them).

Community benefits were calculated using the following factors: lost productivity (net of lost wages), work preseentism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using the following factors: lost wages, caretaker expense and extension of life (if applicable).

094140302.3.3	*3.IT-3.3*	*Diabetes 30 day readmission rate*	
Texas Health Presbyterian Hospital Kaufman			*094140302*
Related Category 1 or 2 Projects:	*094140302.2.2*		
Starting Point/Baseline:	*Estimated diabetes 30 day readmission rate is at 19% Baseline will be confirmed 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)**
Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Goal: 2Q 2013 Milestone 1 Estimated Incentive Payment *(maximum amount):* $ **852** **Milestone 2** [P- 2]: Establish baseline rates Data Source: Internal database Goal: 3Q 2013 Milestone 2 Estimated Incentive Payment: $ **852** **Milestone 3** [P- 3]: Develop and test data systems Data Source: Internally developed database using EMR data to monitor project and produce reports. Goal: 4Q 2013	**Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Goal: 2Q2014 Process Milestone 4 Estimated Incentive Payment: $ **1,346** **Milestone 5** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Goal: 4Q 2014 Milestone 5 Estimated Incentive Payment: $**1,346** **Outcome Improvement Target 1** [IT-3.2]: Diabetes 30 day readmission rate	**Outcome Improvement Target 2** [IT-3.2]: Diabetes 30 day readmission rate Goal: 6% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment*:* $4,319	**Outcome Improvement Target 3** [IT-3.2]: Diabetes 30 day readmission rate Goal: 10% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 3 Estimated Incentive Payment*:* $10,329

094140302.3.3	*3.IT-3.3*	*Diabetes 30 day readmission rate*	
Texas Health Presbyterian Hospital Kaufman			*094140302*
Related Category 1 or 2 Projects:	*094140302.2.2*		
Starting Point/Baseline:	*Estimated diabetes 30 day readmission rate is at 19% Baseline will be confirmed 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)**
Milestone 3 Estimated Incentive Payment: $**851**	Goal: 3% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment*:* $ **1,346**		
Year 2 Estimated Milestone Bundle Amount: $2,555*	Year 3 Estimated Milestone Bundle Amount: $4,038*	Year 4 Estimated Milestone Bundle Amount: $4,319*	Year 5 Estimated Milestone Bundle Amount: $10,329*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $21,241			

***Annual estimated milestone payments to be equally distributed among all milestones in that year**
Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 project

Title of Outcome Measures (Improvement Target): IT-12.1 - Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)

Unique RHP outcomes identification number: 126686802.3.1

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-12.1 Breast Cancer Screening

This outcome measure is a measure of the number of eligible women who get screening mammography as a screen for breast cancer. The measure will be defined as follows:

Numerator: Number of eligible 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.

Process and Improvement Milestones

The milestones that will be used for this measure will include the following:

DY2 – determination of baseline and create registry of eligible women; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – Increase the percentage of eligible women who get screening mammography by: number to be determined over baseline
DY4 – Increase the percentage of eligible women who get screening mammography by: number to be determined over DY3
DY5 – Increase the percentage of eligible women who get screening mammography by: number to be determined over DY4

Data Source: EHR, Claims

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. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce the incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier

and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden. Mammogram provides such a test for women.

Outcome Measure Valuation

In the rationale for this project, the magnitude of the problem of breast cancer screening was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as needed screening for breast cancer. This project is scalable to any size population of eligible women. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from breast cancer are prevented and the costs of hospitalization for breast cancer can be avoided. In addition, screening for breast cancer in eligible women was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.1.1: UT Southwestern Medical Center is in the process of establishing a new multispecialty clinic in Dallas County that is comprised of both Primary Care and Specialty Care Services. This proposal addresses solely the Primary Care Clinic Services.

Unique Cat 3 ID: 126686802.3.1	*Reference Number: IT-12.1*	*Breast cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline mammography rates. Goal: Establish the baseline for the number of women patient's aged 40-69 that have received an annual mammogram. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3 [P-3]:** Develop and test data systems; Goal: Development of registry of eligible cohort and reporting capability of detecting members of	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities. Goal: 1) Improve accuracy and reliability of registry and reporting of eligible cohort of women who need breast cancer screening and 2) improvement of intervention activities. Data Source: EHR **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-12.1]: Improvement Target: Outcome Increase baseline rate of women patients receiving an annual mammogram by **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-12.1]: Improvement Target: Outcome Increase baseline rate of women patients receiving an annual mammogram by **TBD** **Outcome Improvement Target 2 Payment*:*** $ 316,623

Unique Cat 3 ID: 126686802.3.1	*Reference Number: IT-12.1*	*Breast cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
cohort who do not get goal screening. **Process Milestone 3 Estimated Incentive Payment**: $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measures (Improvement Target): IT-12.3 - Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)

Unique RHP outcome identification number: 126686802.3.2

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-12.3 Colorectal Cancer Screening

Colon cancer is a common cause of cancer death and the outcomes of colon cancer can be improved by appropriate screening. This project will improve the rate of colon cancer screening in the targeted population. The definition of the measure will be as follows:

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, or colonoscopy every 10 years
Denominator: Number of adults aged 50 to 75 in our patient population. Adults with colorectal cancer or total colectomy are excluded.

Process and Improvement Milestones

The milestones that will be used for this project include the following:

DY2 – establish baseline and registry for eligible patients; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – develop implementation strategy for colon cancer screening for eligible population
DY4 – increase percent of eligible patients that get screening by number TBD
DY5 – increase percent of eligible patients that get screening by number TBD

Data Source: EHR, Claims

Rationale

A 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. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce the incidence of

and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as needing screening for colon cancer. This project is scalable to any size population of eligible patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from colon cancer are prevented and the costs of hospitalization for colon cancer can be avoided. In addition, screening for colon cancer in eligible patients was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects:

126686802.1.1: UT Southwestern Medical Center is in the process of establishing a new multispecialty clinic in Dallas County that is comprised of both Primary Care and Specialty Care Services. This proposal addresses solely the Primary Care Clinic Services.

Unique Cat 3 ID: 126686802.3.2	*Reference Number: IT-12.3*	*Colorectal cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline colon cancer screening rates Goal: Establish the baseline for the number of adult patient's aged 50 to 75 that have received one of the following screenings: fecal occult blood test yearly, flexible sigmoidoscopy every five years, or colonoscopy every 10 years. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3 [P-3]:** Develop and test data systems; Develop data system capability to establish patient registry of eligible	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data and reporting accuracy of patient registry and improve intervention effectiveness Data Source: EHR **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-12.3]: Improvement Target: **Outcome** Increase proportion of patients receiving colon cancer screening by **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-12.3]: Improvement Target: **Outcome** Increase proportion of patients receiving colon cancer screening by **TBD** **Outcome Improvement Target 2 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.2	*Reference Number: IT-12.3*	*Colorectal cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
patients for colon cancer screening **Process Milestone 3 Payment:** $19,639			
Year 2 Estimated Outcome Amount:: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount**: $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): IT-12.4 - Pneumonia vaccination status for older adults

Unique RHP outcome identification number: 126686802.3.3

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-12.4 Pneumonia vaccination status for older adults

This project will evaluate the percent of eligible patients who get recommended vaccination for Pneumococcal pneumonia. The measure will be defined as follows:

Numerator: The number of eligible patients age 65 and older that have ever received a pneumonia vaccine

Denominator: Number of adults aged 64 and older in the patient or target population.

Process and Improvement Milestones

The milestones for this project will include the following:

DY2 – establish baseline and eligible patient registry; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – Develop implementation plan for vaccination strategy
DY4 – increase the percent of eligible patients who get vaccination by number TBD
DY5 – increase the percent of eligible patients who get vaccination by number TBD

Data Source: EHR, Claims

Rationale

Vaccination of elderly patients for pneumococcal pneumonia is a well establish health maintenance performance measure. It is an effective preventive measure for this common condition that has a high mortality in the elderly. Measurement of the percent of patients in a population of elderly patients is a well established measure of quality of care in primary care practices.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as needing pneumococcal vaccine. This project is scalable to any size population of eligible patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from pneumococcal pneumonia and sepsis are reduced and the costs of hospitalization for pneumococcal infection can be avoided. In addition, providing pneumococcal vaccination for eligible patients was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.1.1: UT Southwestern Medical Center is in the process of establishing a new multispecialty clinic in Dallas County that is comprised of both Primary Care and Specialty Care Services. This proposal addresses solely the Primary Care Clinic Services.

Unique Cat 3 ID: 126686802.3.3	*Reference Number: IT-12.4*	*Pneumonia vaccination status for older adults*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment *:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline pneumococcal vaccine rates Goal: Establish the baseline for pneumococcal vaccination in the number of adults aged 64 and older in our patient population. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3 [P-3]:** Develop and test data systems; Goal: data system capable of establishing and monitoring registry of eligible patients for receiving	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data collection and registry functions and improve intervention activities Data Source: EHR Process Milestone 4 Estimated Incentive Payment: $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices. Process Milestone 5 Estimated Incentive Payment: $68,147	**Outcome Improvement Target 1** [IT-12.4]: Improvement Target: **Outcome** Increase the proportion of eligible patients who have ever received pneumococcal vaccination by number **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-12.4]: Improvement Target: Increase the proportion of eligible patients who have ever received pneumococcal vaccination by number **TDB** **Outcome Improvement Target 1 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.3	*Reference Number: IT-12.4*	*Pneumonia vaccination status for older adults*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
vaccine **Process Milestone 3 Payment:** $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measures (Improvement Target): IT-12.1 - Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)

Unique RHP outcomes identification number: 126686802.3.4

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-12.1 Breast Cancer Screening

This outcome measure is a measure of the number of eligible women who get screening mammography as a screen for breast cancer. The measure will be defined as follows:

Numerator: Number of eligible 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.

Process and Improvement Milestones

The milestones that will be used for this measure will include the following:

DY2 – determination of baseline and create registry of eligible women; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – Increase the percentage of eligible women who get screening mammography by: number to be determined over baseline
DY4 – Increase the percentage of eligible women who get screening mammography by: number to be determined over DY3
DY5 – Increase the percentage of eligible women who get screening mammography by: number to be determined over DY4

Data Source: EHR, Claims

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. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce the incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier

and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden. Mammogram provides such a test for women.

Outcome Measure Valuation

In the rationale for this project, the magnitude of the problem of breast cancer screening was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as needed screening for breast cancer. This project is scalable to any size population of eligible women. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from breast cancer are prevented and the costs of hospitalization for breast cancer can be avoided. In addition, screening for breast cancer in eligible women was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.1.2: UT Southwestern proposes to expand the primary care capacity in the UTSCAP Primary Care Network to better accommodate the needs of RHP 9 patients and the community.

Unique Cat 3 ID: 126686802.3.4	*Reference Number: IT-12.1*	*Breast cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects::	*126686802.1.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline mammography rates. Goal: Establish the baseline for the number of women patient's aged 40-69 that have received an annual mammogram. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Development of registry of eligible cohort and reporting capability of detecting members of	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities. Goal: 1) Improve accuracy and reliability of registry and reporting of eligible cohort of women who need breast cancer screening and 2) improvement of intervention activities. Data Source: EHR **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-12.1]: Improvement Target: Outcome Increase baseline rate of women patients receiving an annual mammogram by **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-12.1]: Improvement Target: Outcome Increase baseline rate of women patients receiving an annual mammogram by **TBD** **Outcome Improvement Target 2 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.4	*Reference Number: IT-12.1*	*Breast cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects::	*126686802.1.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
cohort who do not get goal screening. Process Milestone 3 Estimated Incentive Payment: $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measures (Improvement Target): Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)

Unique RHP outcome identification number: 126686802.3.5

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-12.3 Colorectal Cancer Screening

Colon cancer is a common cause of cancer death and the outcomes of colon cancer can be improved by appropriate screening. This project will improve the rate of colon cancer screening in the targeted population. The definition of the measure will be as follows:

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, or colonoscopy every 10 years
Denominator: Number of adults aged 50 to 75 in our patient population. Adults with colorectal cancer or total colectomy are excluded.

Process and Improvement Milestones

The milestones that will be used for this project include the following:

DY2 – establish baseline and registry for eligible patients; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – develop implementation strategy for colon cancer screening for eligible population
DY4 – increase percent of eligible patients that get screening by number ***TBD***
DY5 – increase percent of eligible patients that get screening by number ***TBD***

Data Source: EHR, Claims

Rationale

A 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. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce the incidence of

and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as needing screening for colon cancer. This project is scalable to any size population of eligible patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from colon cancer are prevented and the costs of hospitalization for colon cancer can be avoided. In addition, screening for colon cancer in eligible patients was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.1.2: UT Southwestern Medical Center is in the process of establishing a new multispecialty clinic in Dallas County that is comprised of both Primary Care and Specialty Care Services. This proposal addresses solely the Primary Care Clinic Services.

Unique Cat 3 ID: 126686802.3.5	*Reference Number: IT-12.3*	*Colorectal cancer screening*	
The University of Texas Southwestern Medical Center– Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline colon cancer screening rates Goal: Establish the baseline for the number of adult patient's aged 50 to 75 that have received one of the following screenings: fecal occult blood test yearly, flexible sigmoidoscopy every five years, or colonoscopy every 10 years. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Develop data system capability to establish patient registry of eligible patients for colon cancer screening	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data and reporting accuracy of patient registry and improve intervention effectiveness Data Source: EHR **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-12.3]: Improvement Target: **Outcome** Increase proportion of patients receiving colon cancer screening by **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2**[IT-12.3]: Improvement Target: **Outcome** Increase proportion of patients receiving colon cancer screening by **TBD** **Outcome Improvement Target 2 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.5	*Reference Number: IT-12.3*	*Colorectal cancer screening*	
The University of Texas Southwestern Medical Center– Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 3 Payment: $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount**: $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): Pneumonia vaccination status for older adults

Unique RHP outcome identification number: 126686802.3.6

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW")/TPI 126686802

Outcome Measure Description

IT-12.4 Pneumonia vaccination status for older adults

This project will evaluate the percent of eligible patients who get recommended vaccination for Pneumococcal pneumonia. The measure will be defined as follows:

Numerator: The number of eligible patients age 65 and older that have ever received a pneumonia vaccine

Denominator: Number of adults aged 64 and older in the patient or target population.

Process and Improvement Milestones

The milestones for this project will include the following:

DY2 – establish baseline and eligible patient registry; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – Develop implementation plan for vaccination strategy
DY4 – increase the percent of eligible patients who get vaccination by number ***TBD***
DY5 – increase the percent of eligible patients who get vaccination by number ***TBD***

Data Source: EHR, Claims

Rationale

Vaccination of elderly patients for pneumococcal pneumonia is a well establish health maintenance performance measure. It is an effective preventive measure for this common condition that has a high mortality in the elderly. Measurement of the percent of patients in a population of elderly patients is a well established measure of quality of care in primary care practices.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the

medical needs of those patients identified as needing pneumococcal vaccine. This project is scalable to any size population of eligible patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from pneumococcal pneumonia and sepsis are reduced and the costs of hospitalization for pneumococcal infection can be avoided. In addition, providing pneumococcal vaccination for eligible patients was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.1.2: UT Southwestern Medical Center is in the process of establishing a new multispecialty clinic in Dallas County that is comprised of both Primary Care and Specialty Care Services. This proposal addresses solely the Primary Care Clinic Services.

Unique Cat 3 ID: 126686802.3.6	*Reference Number: IT-12.4*	*Pneumonia vaccination status for older adults*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment *:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline pneumococcal vaccine rates Goal: Establish the baseline for pneumococcal vaccination in the number of adults aged 64 and older in our patient population. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: data system capable of establishing and monitoring registry of eligible patients for receiving	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data collection and registry functions and improve intervention activities Data Source: EHR Process Milestone 4 Estimated Incentive Payment: $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices. Process Milestone 5 Estimated Incentive Payment: $68,147	**Outcome Improvement Target 1** [IT-12.4]: Improvement Target: **Outcome** Increase the proportion of eligible patients who have ever received pneumococcal vaccination by number **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-12.4]: Improvement Target: Increase the proportion of eligible patients who have ever received pneumococcal vaccination by number **TDB** **Outcome Improvement Target 1 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.6	*Reference Number: IT-12.4*	*Pneumonia vaccination status for older adults*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
vaccine **Process Milestone 3 Payment:** $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measures (Improvement Target): Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)

Unique RHP outcomes identification number: 126686802.3.7

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-12.1 Breast Cancer Screening

This outcome measure is a measure of the number of eligible women who get screening mammography as a screen for breast cancer. The measure will be defined as follows:

Numerator: Number of eligible 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.

Process and Improvement Milestones

The milestones that will be used for this measure will include the following:

DY2 – determination of baseline and create registry of eligible women; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – Increase the percentage of eligible women who get screening mammography by: number to be determined over baseline
DY4 – Increase the percentage of eligible women who get screening mammography by: number to be determined over DY3
DY5 – Increase the percentage of eligible women who get screening mammography by: number to be determined over DY4

Data Source: EHR, Claims

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. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce the incidence of

and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden. Mammogram provides such a test for women.

Outcome Measure Valuation

In the rationale for this project, the magnitude of the problem of breast cancer screening was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as needed screening for breast cancer. This project is scalable to any size population of eligible women. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from breast cancer are prevented and the costs of hospitalization for breast cancer can be avoided. In addition, screening for breast cancer in eligible women was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.1.3: UT Southwestern proposes to develop and implement a quality incentive program to improve the delivery of safe, quality primary care services in our community.

Unique Cat 3 ID: 126686802.3.7	*Reference Number: IT-12.1*	*Breast cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.3*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline mammography rates. Goal: Establish the baseline for the number of women patient's aged 40-69 that have received an annual mammogram. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Development of registry of eligible cohort and reporting capability of detecting members of	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities. Goal: 1) Improve accuracy and reliability of registry and reporting of eligible cohort of women who need breast cancer screening and 2) improvement of intervention activities. Data Source: EHR **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-12.1]: Improvement Target: Outcome Increase baseline rate of women patients receiving an annual mammogram by **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-12.1]: Improvement Target: Outcome Increase baseline rate of women patients receiving an annual mammogram by **TBD** **Outcome Improvement Target 2 Payment*:*** $ 316,623

Unique Cat 3 ID: 126686802.3.7	*Reference Number: IT-12.1*	*Breast cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.3*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
cohort who do not get goal screening. **Process Milestone 3 Estimated Incentive Payment**: $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measures (Improvement Target): Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)

Unique RHP outcome identification number: 126686802.3.8

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-12.3 Colorectal Cancer Screening

Colon cancer is a common cause of cancer death and the outcomes of colon cancer can be improved by appropriate screening. This project will improve the rate of colon cancer screening in the targeted population. The definition of the measure will be as follows:

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, or colonoscopy every 10 years
Denominator: Number of adults aged 50 to 75 in our patient population. Adults with colorectal cancer or total colectomy are excluded.

Process and Improvement Milestones

The milestones that will be used for this project include the following:

DY2 – establish baseline and registry for eligible patients; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – develop implementation strategy for colon cancer screening for eligible population
DY4 – increase percent of eligible patients that get screening by number ***TBD***
DY5 – increase percent of eligible patients that get screening by number ***TBD***

Data Source: EHR, Claims

Rationale

A 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. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce the incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier

and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as needing screening for colon cancer. This project is scalable to any size population of eligible patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from colon cancer are prevented and the costs of hospitalization for colon cancer can be avoided. In addition, screening for colon cancer in eligible patients was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.1.3: UT Southwestern proposes to develop and implement a quality incentive program to improve the delivery of safe, quality primary care services in our community.

Unique Cat 3 ID: 126686802.3.8	*Reference Number: IT-12.3*	*Colorectal cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.3*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline colon cancer screening rates Goal: Establish the baseline for the number of adult patient's aged 50 to 75 that have received one of the following screenings: fecal occult blood test yearly, flexible sigmoidoscopy every five years, or colonoscopy every 10 years. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Develop data system capability to establish patient registry of eligible	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data and reporting accuracy of patient registry and improve intervention effectiveness Data Source: EHR **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-12.3]: Improvement Target: **Outcome** Increase proportion of patients receiving colon cancer screening by **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2**[IT-12.3]: Improvement Target: **Outcome** Increase proportion of patients receiving colon cancer screening by **TBD** **Outcome Improvement Target 2 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.8	*Reference Number: IT-12.3*	*Colorectal cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.3*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
patients for colon cancer screening **Process Milestone 3 Payment:** $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount**: $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): Pneumonia vaccination status for older adults

Unique RHP outcome identification number: 126686802.3.9

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW")/TPI 126686802

Outcome Measure Description

IT-12.4 Pneumonia vaccination status for older adults

This project will evaluate the percent of eligible patients who get recommended vaccination for Pneumococcal pneumonia. The measure will be defined as follows:

Numerator: The number of eligible patients age 65 and older that have ever received a pneumonia vaccine

Denominator: Number of adults aged 64 and older in the patient or target population.

Process and Improvement Milestones

The milestones for this project will include the following:

DY2 – establish baseline and eligible patient registry; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – Develop implementation plan for vaccination strategy
DY4 – increase the percent of eligible patients who get vaccination by number ***TBD***
DY5 – increase the percent of eligible patients who get vaccination by number ***TBD***

Data Source: EHR, Claims

Rationale

Vaccination of elderly patients for pneumococcal pneumonia is a well establish health maintenance performance measure. It is an effective preventive measure for this common condition that has a high mortality in the elderly. Measurement of the percent of patients in a population of elderly patients is a well established measure of quality of care in primary care practices.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the

medical needs of those patients identified as needing pneumococcal vaccine. This project is scalable to any size population of eligible patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from pneumococcal pneumonia and sepsis are reduced and the costs of hospitalization for pneumococcal infection can be avoided. In addition, providing pneumococcal vaccination for eligible patients was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.1.3: UT Southwestern proposes to develop and implement a quality incentive program to improve the delivery of safe, quality primary care services in our community.

Unique Cat 3 ID: 126686802.3.9	*Reference Number: IT-12.4*	*Pneumonia vaccination status for older adults*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.3*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment *:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline pneumococcal vaccine rates Goal: Establish the baseline for pneumococcal vaccination in the number of adults aged 64 and older in our patient population. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3 [P-3]:** Develop and test data systems; Goal: data system capable of establishing and monitoring registry of eligible patients for receiving vaccine	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data collection and registry functions and improve intervention activities Data Source: EHR **Process Milestone 4 Estimated Incentive Payment**: $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices. **Process Milestone 5 Estimated Incentive Payment:** $68,147	**Outcome Improvement Target 1** [IT-12.4]: Improvement Target: **Outcome** Increase the proportion of eligible patients who have ever received pneumococcal vaccination by number **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-12.4]: Improvement Target: Increase the proportion of eligible patients who have ever received pneumococcal vaccination by number **TDB** **Outcome Improvement Target 1 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.9	*Reference Number: IT-12.4*	*Pneumonia vaccination status for older adults*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.3*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 3 Payment: $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): Cholesterol management for patients with cardiovascular conditions NCQA-HEDIS 2012 (Standalone Measure)

Unique RHP outcome identification number: 126686802.3.10

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-1.6 Cholesterol management for patients with cardiovascular conditions

This project will assess and improve the percent of patients with known coronary artery disease who have their LDL adequately controlled by current standards. The definition of the measured will be as follows:

Numerator: Number of patients who had each of the following during the reporting period:
Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year.LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL.

Denominator: Patients aged 18 to 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1 through November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during measurement year and the year prior to the measurement year.

Process and Improvement Milestones

Milestones that will be determined in the project include:

DY2 – assessment of baseline percent of patients controlled and establishment of hypercholesterolemia registry; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – Assess data accuracy and develop management strategy
DY4 - increase the percent of patients with adequate cholesterol control by **TBD**
DY5 - increase the percent of patients with adequate cholesterol control by **TBD**

Data Source: EHR, Claims

Rationale

Total blood cholesterol is directly related to the development of coronary artery disease (CAD) and coronary heart disease (CHD), with most of the risk being associated with low-density lipoprotein cholesterol (LDL-C). When LDL-C levels are high, cholesterol can build up within the walls of the arteries, causing atherosclerosis, the build-up of plaque. Hemorrhaging or clot formation can occur at the site of plaque build-up, blocking arteries and causing heart attack and stroke. Reducing cholesterol in patients with known heart disease is critically important, as treatment can reduce morbidity (heart attack and stroke) and mortality by as much as 40%. The National Cholesterol Education Program (NCEP) has established guidelines for managing cholesterol levels in patients with heart disease. The guidelines established the need for close monitoring of LDL cholesterol in patients with coronary heart disease and set a target for LDL-C of less than or equal to 100 mg/dL for such patients. Cholesterol screening and control depends on the combined efforts of patient, physician and organization. Lifestyle factors and new medications offer tangible means for reducing cholesterol and the risk of heart disease.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients cardiovascular disease who need screening for adequate control of cholesterol. This project is scalable to any size population of eligible patients. The populations served will be the primary care and cardiology patients of the UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from cardiovascular disease are decreased with subsequent reduction of the costs of hospitalization for these patients. Screening for cholesterol in this population was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.1.4: UT Southwestern proposes to introduce access to specialty care support and consultation via telemedicine to the UTSCAP Primary Care Network to better accommodate the needs of RHP 9 patients and the community.

Unique Cat 3 ID: 126686802.3.10	*Reference Number: IT-1.6*	*Cholesterol management in patients with cardiovascular conditions*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.4*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment *:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline of LDL screening and percent of patients with LDL, 100 Goal: Establish the baseline for patients aged 18 to 75 years who were discharged alive for AMI, CABG, or PCIe Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Develop a data registry of eligible patients with cardiovascular hear diseas and capability of detecting those patients who do not receive adequate cholesterol	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data accuracy in patient registry and intervention activities Data Source: EHR and administrative records **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-1.6]: Improvement Target: **Outcome** Increase LDL screening rate and number of patients with LDL<100 by **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-1.6]: Improvement Target: **Outcome** Increase LDL screening rate and number of patients with LDL<100 by **TBD** **Outcome Improvement Target 2 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.10	*Reference Number: IT-1.6*	*Cholesterol management in patients with cardiovascular conditions*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.4*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
screening **<u>Process Milestone 3 Payment</u>:** $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Title of Outcome Measure (Improvement Target): Controlling high blood pressure NCQA-HEDIS 2012, NQF 0018 (Standalone Measure)

Unique RHP outcome identification number: 126686802.3.11

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-1.7 Controlling high blood pressure

This measure will assess the number of patients with hypertension who have their blood pressure controlled to at least 140/90 during the measurement year. The measure will be defined as:

Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year

Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension

Process and Improvement Milestones

Milestone of this project will include:

DY2 – assessment of baseline percent of patients controlled of study population and establishment of hypertension registry; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – increase the percent of patients with adequate hypertension control by **TBD**
DY4 - increase the percent of patients with adequate hypertension control by **TBD**
DY5 - increase the percent of patients with adequate hypertension control by **TBD**

Data Source: EHR, Claims

Rationale

Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensive patients, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates

that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee.

Outcome Measure Valuation

In the rationale for this project, the magnitude of the problem of uncontrolled hypertension was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative and address the medical needs of those patients identified as having a high risk of developing complications. This project is scalable to any size population of hypertensive patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from hypertension are prevented and the costs of hospitalization for complications from hypertension can be avoided. In addition, control of hypertension was identified as one of the community priorities in the Community needs assessment.

Related Category 1 or 2 Projects

126686802.1.4: UT Southwestern proposes to introduce access to specialty care support and consultation via telemedicine to the UTSCAP Primary Care Network to better accommodate the needs of RHP 9 patients and the community.

Unique Cat 3 ID: 126686802.3.11	*Reference Number: IT-1.7*	*Controlling high blood pressure*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.4*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment:** $19,639 **Process Milestone 2** [P-2]: Establish baseline blood pressure control rates rates Goal: Establish the baseline for patients aged 18 to 85 years whose most recent BP is adequately controlled (BP < 140/90 mm). Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Develop capability to collect,	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data collection, reporting and analytic functions as well as intervention strategies Data Source: EHR and administrative records **Process Milestone 4 Payment:** $68,147 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-1.7]: Improvement Target: **Outcome** Improve blood pressure control by **TBD** **Outcome Improvement Target 1 Payment:** $145,803	**Outcome Improvement Target 2** [IT-1.7]: Improvement Target**: Outcome** Improve blood pressure control by **TBD** **Outcome Improvement Target 1 Payment:** $316,623

Unique Cat 3 ID: 126686802.3.11	*Reference Number: IT-1.7*	*Controlling high blood pressure*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.4*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
analyze and report clinical and administrative data to support project **Process Milestone 3 Payment:** $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): Diabetes care: HgbA1c poor control (>9.0%) NQF 0059 (Standalone Measure)

Unique RHP outcome identification number: 126686802.3.12

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW")/TPI 126686802

Outcome Measure Description:

IT-1.10 Diabetes care: HgbA1c poor control (>9.0%)

This measure will assess how well diabetic patients have their blood glucose controlled. The definition of the measure is as follows:

1. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

2. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

3. This metric will be calculated quarterly for the primary care practice and for each individual provider. The proportion of patients with poor control will be trended and the outcome is to decrease this number by 10% in year 4 and 10% in year 5 if the proportion of patients with a HgbA1c more than 9% is greater than 15%. If the number is less than 15% the outcome metric will be to maintain the number at less than 15%. The milestones are as described in the valuation. A diabetes registry will be developed and data collected for all HgbA1c measurements for all diabetic patients. This registry and data will be validated and the accuracy of the registry and all administrative and clinical data will be checked and improved using a PDCA methodology. Reports will be given to providers at least quarterly

Process and Improvement Milestones

The milestone for this project include

DY2 – establishment of baseline and registry of eligible diabetic patients in the population; Outcome Improvement Targets will be determined in DY2 for DY3 implementation

DY3 – establish treatment protocols and best practices for controlling glucose and test data systems

DY4 – decrease the percent of patients with HgbA1c > 0.9% by TBD

DY5 - decrease the percent of patients with HgbA1c > 0.9% by TBD

Data Source: EHR, Registry, Claims, Administrative clinical data

Rationale

Diabetes has been and remains a major cause of morbidity and mortality in the US. It is also one of the most costly and highly prevalent chronic diseases in this country. 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 the disease is 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.

A reliable method of assessing the control of diabetes is periodically measuring the glycosylated hemoglobin (HgbA1c) which provides a reliable estimate of the average glucose of patients over several weeks. Studies have shown that adequate control of diabetes as measured by HgbA1c reduces complications, prevents hospitalizations and prolong life and quality of life. Consequently, developing a system to monitor patients with diabetes with regular assessment of HgbA1c and intervening in those with levels indicating poor control of diabetes will improve the outcomes of these patients. If applied nationally diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

Outcome Measure Valuation:

In the rationale for this project, the magnitude of the problem of uncontrolled diabetes was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative and address the medical needs of those patients identified as having a high risk of developing complications. This project is scalable to any size population of diabetic patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from diabetes are prevented and the costs of hospitalization for complications from diabetes can be avoided. In addition, control of diabetes was identified as one of the community priorities in the Community needs assessment.

Related Category 1 or 2 Projects

126686802.1.4: UT Southwestern proposes to introduce access to specialty care support and consultation via telemedicine to the UTSCAP Primary Care Network to better accommodate the needs of RHP 9 patients and the community.

Unique Cat 3 ID: 126686802.3.12	*Reference Number: IT - 1.10*	*Diabetes care: HgbA1c poor control (>9.0%)*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.4*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment:** $19,639 **Process Milestone 2** [P-2]: Establish baseline HgbA1c rates Goal: Establish the baseline for patients aged 18 to 75 years who had HBA1c > 0.9%. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Test reporting accuracy of diabetic registry and ability to detect patients not meeting goal **Process Milestone 3 Payment:**	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities. Goal: Improve registry data, reporting and improvement activities. Data Source: EHR and administrative records **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-1.10]: Improvement Target: **TBD** **Outcome Improvement Target 1 Payment:** $145,803	**Outcome Improvement Target 2**[IT-1.10]: Improvement Target: **TBD** **Outcome Improvement Target 2 Payment:** $316,623

Unique Cat 3 ID: 126686802.3.12	*Reference Number: IT - 1.10*	*Diabetes care: HgbA1c poor control (>9.0%)*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.4*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
$19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): Cholesterol management for patients with cardiovascular conditions NCQA-HEDIS 2012 (Standalone Measure)

Unique RHP outcome identification number: 126686802.3.13

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-1.6 Cholesterol management for patients with cardiovascular conditions

This project will assess and improve the percent of patients with known coronary artery disease who have their LDL adequately controlled by current standards. The definition of the measured will be as follows:

Numerator: Number of patients who had each of the following during the reporting period:
Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year.LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL.

Denominator: Patients aged 18 to 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1 through November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during measurement year and the year prior to the measurement year.

Process and Improvement Milestones

Milestones that will be determined in the project include:

DY2 – assessment of baseline percent of patients controlled and establishment of hypercholesterolemia registry; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – Assess data accuracy and develop management strategy
DY4 - increase the percent of patients with adequate cholesterol control by **TBD**
DY5 - increase the percent of patients with adequate cholesterol control by **TBD**

Data Source: EHR, Claims

Rationale

Total blood cholesterol is directly related to the development of coronary artery disease (CAD) and coronary heart disease (CHD), with most of the risk being associated with low-density lipoprotein cholesterol (LDL-C). When LDL-C levels are high, cholesterol can build up within the walls of the arteries, causing atherosclerosis, the build-up of plaque. Hemorrhaging or clot formation can occur at the site of plaque build-up, blocking arteries and causing heart attack and stroke. Reducing cholesterol in patients with known heart disease is critically important, as treatment can reduce morbidity (heart attack and stroke) and mortality by as much as 40%. The National Cholesterol Education Program (NCEP) has established guidelines for managing cholesterol levels in patients with heart disease. The guidelines established the need for close monitoring of LDL cholesterol in patients with coronary heart disease and set a target for LDL-C of less than or equal to 100 mg/dL for such patients. Cholesterol screening and control depends on the combined efforts of patient, physician and organization. Lifestyle factors and new medications offer tangible means for reducing cholesterol and the risk of heart disease.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients cardiovascular disease who need screening for adequate control of cholesterol. This project is scalable to any size population of eligible patients. The populations served will be the primary care and cardiology patients of the UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from cardiovascular disease are decreased with subsequent reduction of the costs of hospitalization for these patients. Screening for cholesterol in this population was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.1.5: UT Southwestern Medical Center is in the process of establishing a new multispecialty clinic in Dallas County that is comprised of both Specialty Care and Primary Care Services. This proposal addresses solely the Specialty Care Clinic components.

Unique Cat 3 ID: 126686802.3.13	*Reference Number: IT-1.6*	*Cholesterol management in patients with cardiovascular conditions*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.5*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment *:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline of LDL screening and percent of patients with LDL, 100 Goal: Establish the baseline for patients aged 18 to 75 years who were discharged alive for AMI, CABG, or PCIe Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Develop a data registry of eligible patients with cardiovascular	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data accuracy in patient registry and intervention activities Data Source: EHR and administrative records **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-1.6]: Improvement Target: **Outcome** Increase LDL screening rate and number of patients with LDL<100 by **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-1.6]: Improvement Target: **Outcome** Increase LDL screening rate and number of patients with LDL<100 by **TBD** **Outcome Improvement Target 2 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.13	*Reference Number: IT-1.6*	*Cholesterol management in patients with cardiovascular conditions*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.5*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
hear diseas and capability of detecting those patients who do not receive adequate cholesterol screening **Process Milestone 3 Payment:** $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): Controlling high blood pressure NCQA-HEDIS 2012, NQF 0018 (Standalone Measure)

Unique RHP outcome identification number: 126686802.3.14

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-1.7 Controlling high blood pressure

This measure will assess the number of patients with hypertension who have their blood pressure controlled to at least 140/90 during the measurement year. The measure will be defined as:

Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year

Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension

Process and Improvement Milestones

Milestone of this project will include:

DY2 – assessment of baseline percent of patients controlled of study population and establishment of hypertension registry; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – increase the percent of patients with adequate hypertension control by **TBD**
DY4 - increase the percent of patients with adequate hypertension control by **TBD**
DY5 - increase the percent of patients with adequate hypertension control by **TBD**

Data Source: EHR, Claims

Rationale

Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensive patients, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates

that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee.

Outcome Measure Valuation

In the rationale for this project, the magnitude of the problem of uncontrolled hypertension was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative and address the medical needs of those patients identified as having a high risk of developing complications. This project is scalable to any size population of hypertensive patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from hypertension are prevented and the costs of hospitalization for complications from hypertension can be avoided. In addition, control of hypertension was identified as one of the community priorities in the Community needs assessment.

Related Category 1 or 2 Projects

126686802.1.5: UT Southwestern Medical Center is in the process of establishing a new multispecialty clinic in Dallas County that is comprised of both Specialty Care and Primary Care Services. This proposal addresses solely the Specialty Care Clinic components.

Unique Cat 3 ID: 126686802.3.14	*Reference Number: IT-1.7*	*Controlling high blood pressure*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.5*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline blood pressure control rates rates Goal: Establish the baseline for patients aged 18 to 85 years whose most recent BP is adequately controlled (BP < 140/90 mm). Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Develop capability to collect,	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data collection, reporting and analytic functions as well as intervention strategies Data Source: EHR and administrative records **Process Milestone 4 Payment:** $68,147 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-1.7]: Improvement Target: **Outcome** Improve blood pressure control by **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-1.7]: Improvement Target**: Outcome** Improve blood pressure control by **TBD** **Outcome Improvement Target 1 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.14	*Reference Number: IT-1.7*	*Controlling high blood pressure*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.5*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
analyze and report clinical and administrative data to support project **Process Milestone 3 Payment:** $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measures (Improvement Target): Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)

Unique RHP outcomes identification number: 126686802.3.15

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-12.1 Breast Cancer Screening

This outcome measure is a measure of the number of eligible women who get screening mammography as a screen for breast cancer. The measure will be defined as follows:

Numerator: Number of eligible 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.

Process and Improvement Milestones

The milestones that will be used for this measure will include the following:

DY2 – determination of baseline and create registry of eligible women; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – Increase the percentage of eligible women who get screening mammography by: number to be determined over baseline
DY4 – Increase the percentage of eligible women who get screening mammography by: number to be determined over DY3
DY5 – Increase the percentage of eligible women who get screening mammography by: number to be determined over DY4

Data Source: EHR, Claims

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. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce the incidence of

and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden. Mammogram provides such a test for women.

Outcome Measure Valuation

In the rationale for this project, the magnitude of the problem of breast cancer screening was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as needed screening for breast cancer. This project is scalable to any size population of eligible women. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from breast cancer are prevented and the costs of hospitalization for breast cancer can be avoided. In addition, screening for breast cancer in eligible women was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.1.6: UT Southwestern proposes to create a population management infrastructure that will enhance improvement capacity through technology, allow the measuring, reporting and driving of quality improvement.

Unique Cat 3 ID: 126686802.3.15	*Reference Number: IT-12.1*	*Breast cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.6*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline mammography rates. Goal: Establish the baseline for the number of women patient's aged 40-69 that have received an annual mammogram. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Development of registry of eligible cohort and reporting capability of detecting members of	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities. Goal: 1) Improve accuracy and reliability of registry and reporting of eligible cohort of women who need breast cancer screening and 2) improvement of intervention activities. Data Source: EHR **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-12.1]: Improvement Target: Outcome Increase baseline rate of women patients receiving an annual mammogram by **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-12.1]: Improvement Target: Outcome Increase baseline rate of women patients receiving an annual mammogram by **TBD** **Outcome Improvement Target 2 Payment*:*** $ 316,623

Unique Cat 3 ID: 126686802.3.15	*Reference Number: IT-12.1*	*Breast cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.6*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
cohort who do not get goal screening. **Process Milestone 3 Estimated Incentive Payment**: $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measures (Improvement Target): Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)

Unique RHP outcome identification number: 126686802.3.16

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-12.3 Colorectal Cancer Screening

Colon cancer is a common cause of cancer death and the outcomes of colon cancer can be improved by appropriate screening. This project will improve the rate of colon cancer screening in the targeted population. The definition of the measure will be as follows:

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, or colonoscopy every 10 years
Denominator: Number of adults aged 50 to 75 in our patient population. Adults with colorectal cancer or total colectomy are excluded.

Process and Improvement Milestones

The milestones that will be used for this project include the following:

DY2 – establish baseline and registry for eligible patients; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – develop implementation strategy for colon cancer screening for eligible population
DY4 – increase percent of eligible patients that get screening by number **TBD**
DY5 – increase percent of eligible patients that get screening by number **TBD**

Data Source: EHR, Claims

Rationale

A 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. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce the incidence of

and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as needing screening for colon cancer. This project is scalable to any size population of eligible patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from colon cancer are prevented and the costs of hospitalization for colon cancer can be avoided. In addition, screening for colon cancer in eligible patients was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.1.6: UT Southwestern proposes to create a population management infrastructure that will enhance improvement capacity through technology, allow the measuring, reporting and driving of quality improvement.

Unique Cat 3 ID: 126686802.3.16	*Reference Number: IT-12.3*	*Colorectal cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.6*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline colon cancer screening rates Goal: Establish the baseline for the number of adult patient's aged 50 to 75 that have received one of the following screenings: fecal occult blood test yearly, flexible sigmoidoscopy every five years, or colonoscopy every 10 years. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Develop data system capability to establish patient registry of eligible	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data and reporting accuracy of patient registry and improve intervention effectiveness Data Source: EHR **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-12.3]: Improvement Target: **Outcome** Increase proportion of patients receiving colon cancer screening by **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2**[IT-12.3]: Improvement Target: **Outcome** Increase proportion of patients receiving colon cancer screening by **TBD** **Outcome Improvement Target 2 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.16	*Reference Number: IT-12.3*	*Colorectal cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.6*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
patients for colon cancer screening **Process Milestone 3 Payment:** $19,639			
Year 2 Estimated Outcome Amount:: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount**: $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): Pneumonia vaccination status for older adults

Unique RHP outcome identification number: 126686802.3.17

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW")/TPI 126686802

Outcome Measure Description

IT-12.4 Pneumonia vaccination status for older adults

This project will evaluate the percent of eligible patients who get recommended vaccination for Pneumococcal pneumonia. The measure will be defined as follows:

Numerator: The number of eligible patients age 65 and older that have ever received a pneumonia vaccine

Denominator: Number of adults aged 64 and older in the patient or target population.

Process and Improvement Milestones

The milestones for this project will include the following:

DY2 – establish baseline and eligible patient registry; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – Develop implementation plan for vaccination strategy
DY4 – increase the percent of eligible patients who get vaccination by number **TBD**
DY5 – increase the percent of eligible patients who get vaccination by number **TBD**

Data Source: EHR, Claims

Rationale

Vaccination of elderly patients for pneumococcal pneumonia is a well establish health maintenance performance measure. It is an effective preventive measure for this common condition that has a high mortality in the elderly. Measurement of the percent of patients in a population of elderly patients is a well established measure of quality of care in primary care practices.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the

medical needs of those patients identified as needing pneumococcal vaccine. This project is scalable to any size population of eligible patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from pneumococcal pneumonia and sepsis are reduced and the costs of hospitalization for pneumococcal infection can be avoided. In addition, providing pneumococcal vaccination for eligible patients was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.1.6: UT Southwestern proposes to create a population management infrastructure that will enhance improvement capacity through technology, allow the measuring, reporting and driving of quality improvement.

Unique Cat 3 ID: 126686802.3.17	*Reference Number: IT-12.4*	*Pneumonia vaccination status for older adults*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.6*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment *:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline pneumococcal vaccine rates Goal: Establish the baseline for pneumococcal vaccination in the number of adults aged 64 and older in our patient population. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: data system capable of establishing and monitoring registry of eligible patients for receiving vaccine	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data collection and registry functions and improve intervention activities Data Source: EHR Process Milestone 4 Estimated Incentive Payment: $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices. Process Milestone 5 Estimated Incentive Payment: $68,147	**Outcome Improvement Target 1** [IT-12.4]: Improvement Target: **Outcome** Increase the proportion of eligible patients who have ever received pneumococcal vaccination by number **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-12.4]: Improvement Target: Increase the proportion of eligible patients who have ever received pneumococcal vaccination by number **TDB** **Outcome Improvement Target 1 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.17	*Reference Number: IT-12.4*	*Pneumonia vaccination status for older adults*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.6*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 3 Payment: $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): Diabetes care: HgbA1c poor control (>9.0%) NQF 0059 (Standalone Measure)

Unique RHP outcome identification number: 126686802.3.18

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW")/TPI 126686802

Outcome Measure Description

IT-1.10 Diabetes care: HgbA1c poor control (>9.0%)

This measure will assess how well diabetic patients have their blood glucose controlled. The definition of the measure is as follows:

- Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
- This metric will be calculated quarterly for the primary care practice and for each individual provider. The proportion of patients with poor control will be trended and the outcome is to decrease this number by 10% in year 4 and 10% in year 5 if the proportion of patients with a HgbA1c more than 9% is greater than 15%. If the number is less than 15% the outcome metric will be to maintain the number at less than 15%. The milestones are as described in the valuation. A diabetes registry will be developed and data collected for all HgbA1c measurements for all diabetic patients. This registry and data will be validated and the accuracy of the registry and all administrative and clinical data will be checked and improved using a PDCA methodology. Reports will be given to providers at least quarterly

Process and Improvement Milestones

The milestones for this project include:

DY2 – establishment of baseline and registry of eligible diabetic patients in the population; Outcome Improvement Targets will be determined in DY2 for DY3 implementation

DY3 – establish treatment protocols and best practices for controlling glucose and test data systems

DY4 – decrease the percent of patients with HgbA1c > 0.9% by TBD

DY5 - decrease the percent of patients with HgbA1c > 0.9% by TBD

Rationale

Diabetes has been and remains a major cause of morbidity and mortality in the US. It is also one of the most costly and highly prevalent chronic diseases in this country. 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 the disease is 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.

A reliable method of assessing the control of diabetes is periodically measuring the glycosylated hemoglobin (HgbA1c) which provides a reliable estimate of the average glucose of patients over several weeks. Studies have shown that adequate control of diabetes as measured by HgbA1c reduces complications, prevents hospitalizations and prolong life and quality of life. Consequently, developing a system to monitor patients with diabetes with regular assessment of HgbA1c and intervening in those with levels indicating poor control of diabetes will improve the outcomes of these patients. If applied nationally diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

Outcome Measure Valuation

In the rationale for this project, the magnitude of the problem of uncontrolled diabetes was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative and address the medical needs of those patients identified as having a high risk of developing complications. This project is scalable to any size population of diabetic patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from diabetes are prevented and the costs of hospitalization for complications from diabetes can be avoided. In addition, control of diabetes was identified as one of the community priorities in the Community needs assessment.

Related Category 1 or 2 Projects

126686802.1.6: UT Southwestern proposes to create a population management infrastructure that will enhance improvement capacity through technology, allow the measuring, reporting and driving of quality improvement.

Unique Cat 3 ID: 126686802.3.18	*Reference Number: IT-1.10*	*Diabetes care: HgbA1c poor control (>9.0%)*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.6*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline HgbA1c rates Goal: Establish the baseline for patients aged 18 to 75 years who had HBA1c > 0.9%. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Test reporting accuracy of diabetic registry and ability to detect patients not meeting goal **Process Milestone 3 Payment:** $19,639	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities. Goal: Improve registry data, reporting and improvement activities. Data Source: EHR and administrative records **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-1.10]: Improvement Target: **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-1.10]: Improvement Target: **TBD** **Outcome Improvement Target 2 Payment*:*** $316,623
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623

Unique Cat 3 ID: 126686802.3.18	*Reference Number: IT-1.10*	*Diabetes care: HgbA1c poor control (>9.0%)*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.6*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measures (Improvement Target): Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)

Unique RHP outcomes identification number: 126686802.3.19

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-12.1 Breast Cancer Screening

This outcome measure is a measure of the number of eligible women who get screening mammography as a screen for breast cancer. The measure will be defined as follows:

Numerator: Number of eligible 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.

Process and Improvement Milestones

The milestones that will be used for this measure will include the following:

DY2 – determination of baseline and create registry of eligible women; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – Increase the percentage of eligible women who get screening mammography by: number to be determined over baseline
DY4 – Increase the percentage of eligible women who get screening mammography by: number to be determined over DY3
DY5 – Increase the percentage of eligible women who get screening mammography by: number to be determined over DY4

Data Source: EHR, Claims

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. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce the incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier

and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden. Mammogram provides such a test for women.

Outcome Measure Valuation

In the rationale for this project, the magnitude of the problem of breast cancer screening was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as needed screening for breast cancer. This project is scalable to any size population of eligible women. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from breast cancer are prevented and the costs of hospitalization for breast cancer can be avoided. In addition, screening for breast cancer in eligible women was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.2.1: UT Southwestern proposes to enhance the delivery of care provided through the Patient-Centered Medical Home (PCMH) model in the UTSCAP Primary Care Network.

Unique Cat 3 ID: 126686802.3.19	*Reference Number: IT-12.1*	*Breast cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline mammography rates. Goal: Establish the baseline for the number of women patient's aged 40-69 that have received an annual mammogram. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Development of registry of eligible cohort and reporting capability of detecting members of	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities. Goal: 1) Improve accuracy and reliability of registry and reporting of eligible cohort of women who need breast cancer screening and 2) improvement of intervention activities. Data Source: EHR **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-12.1]: Improvement Target: Outcome Increase baseline rate of women patients receiving an annual mammogram by **TBD** Data Source: EHR and claims data. **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-12.1]: Improvement Target: Outcome Increase baseline rate of women patients receiving an annual mammogram by **TBD** Data Source: EHR and claims data. **Outcome Improvement Target 2 Payment*:*** $ 316,623

Unique Cat 3 ID: 126686802.3.19	*Reference Number: IT-12.1*	*Breast cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
cohort who do not get goal screening. **Process Milestone 3 Estimated Incentive Payment**: $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measures (Improvement Target): Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)

Unique RHP outcome identification number: 126686802.3.20

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-12.3 Colorectal Cancer Screening

Colon cancer is a common cause of cancer death and the outcomes of colon cancer can be improved by appropriate screening. This project will improve the rate of colon cancer screening in the targeted population. The definition of the measure will be as follows:

> 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, or colonoscopy every 10 years
> Denominator: Number of adults aged 50 to 75 in our patient population. Adults with colorectal cancer or total colectomy are excluded.

Process and Improvement Milestones

The milestones that will be used for this project include the following:

> DY2 – establish baseline and registry for eligible patients; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
> DY3 – develop implementation strategy for colon cancer screening for eligible population
> DY4 – increase percent of eligible patients that get screening by number **TBD**
> DY5 – increase percent of eligible patients that get screening by number **TBD**
>
> Data Source: EHR, Claims

Rationale

A 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. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce the incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier

and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as needing screening for colon cancer. This project is scalable to any size population of eligible patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from colon cancer are prevented and the costs of hospitalization for colon cancer can be avoided. In addition, screening for colon cancer in eligible patients was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.2.1: UT Southwestern proposes to enhance the delivery of care provided through the Patient-Centered Medical Home (PCMH) model in the UTSCAP Primary Care Network.

Unique Cat 3 ID: 126686802.3.20	*Reference Number: IT-12.3*	*Colorectal cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline colon cancer screening rates Goal: Establish the baseline for the number of adult patient's aged 50 to 75 that have received one of the following screenings: fecal occult blood test yearly, flexible sigmoidoscopy every five years, or colonoscopy every 10 years. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Develop data system capability to establish patient registry of eligible	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data and reporting accuracy of patient registry and improve intervention effectiveness Data Source: EHR **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-12.3]: Improvement Target: **Outcome** Increase proportion of patients receiving colon cancer screening by **TBD** Data Source: EHR and claims data. **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2**[IT-12.3]: Improvement Target: **Outcome** Increase proportion of patients receiving colon cancer screening by **TBD** Data Source: EHR and claims data. **Outcome Improvement Target 2 Payment*:*** $316,663

Unique Cat 3 ID: 126686802.3.20	*Reference Number: IT-12.3*	*Colorectal cancer screening*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
patients for colon cancer screening **Process Milestone 3 Payment:** $19,639			
Year 2 Estimated Outcome Amount:: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount**: $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): Pneumonia vaccination status for older adults

Unique RHP outcome identification number: 126686802.3.21

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW")/TPI 126686802

Outcome Measure Description

IT-12.4 Pneumonia vaccination status for older adults

This project will evaluate the percent of eligible patients who get recommended vaccination for Pneumococcal pneumonia. The measure will be defined as follows:

Numerator: The number of eligible patients age 65 and older that have ever received a pneumonia vaccine

Denominator: Number of adults aged 64 and older in the patient or target population.

Process and Improvement Milestones

The milestones for this project will include the following:

DY2 – establish baseline and eligible patient registry; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – Develop implementation plan for vaccination strategy
DY4 – increase the percent of eligible patients who get vaccination by number **TBD**
DY5 – increase the percent of eligible patients who get vaccination by number **TBD**

Data Source: EHR, Claims

Rationale

Vaccination of elderly patients for pneumococcal pneumonia is a well establish health maintenance performance measure. It is an effective preventive measure for this common condition that has a high mortality in the elderly. Measurement of the percent of patients in a population of elderly patients is a well-established measure of quality of care in primary care practices.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as needing pneumococcal vaccine. This project is scalable to any size population of eligible patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from pneumococcal pneumonia and sepsis are reduced and the costs of hospitalization for pneumococcal infection can be avoided. In addition, providing pneumococcal vaccination for eligible patients was identified as one of the community priorities in the Community Needs Assessment.

Related Category 1 or 2 Projects

126686802.2.1: UT Southwestern proposes to enhance the delivery of care provided through the Patient-Centered Medical Home (PCMH) model in the UTSCAP Primary Care Network.

Unique Cat 3 ID: 126686802.3.21	*Reference Number: IT-12.4*	*Pneumonia vaccination status for older adults*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans; Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment *:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline pneumococcal vaccine rates Goal: Establish the baseline for pneumococcal vaccination in the number of adults aged 64 and older in our patient population. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: data system capable of establishing and monitoring registry of eligible patients for receiving vaccine Data Source: Data system reports	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data collection and registry functions and improve intervention activities Data Source: EHR **Process Milestone 4 Estimated Incentive Payment**: $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices. **Process Milestone 5 Estimated Incentive Payment:** $68,147	**Outcome Improvement Target 1** [IT-12.4]: Improvement Target: **Outcome** Increase the proportion of eligible patients who have ever received pneumococcal vaccination by number **TBD** Data Source: EHR and claims data. **Outcome Improvement Target 1 Payment*:*** $ 145,803	**Outcome Improvement Target 2** [IT-12.4]: Improvement Target: Increase the proportion of eligible patients who have ever received pneumococcal vaccination by number **TDB** Data Source: EHR and claims data. **Outcome Improvement Target 1 Payment*:*** $ 316,623

Unique Cat 3 ID: 126686802.3.21	*Reference Number: IT-12.4*	*Pneumonia vaccination status for older adults*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 3 Payment: $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 657,637			

Title of Outcome Measure (Improvement Target): Diabetes care: HgbA1c poor control (>9.0%) NQF 0059 (Standalone Measure)

Unique RHP outcome identification number: 126686802.3.22

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW")/TPI 126686802

Outcome Measure Description

IT-1.10 Diabetes care: HgbA1c poor control (>9.0%)

This measure will assess how well diabetic patients have their blood glucose controlled. The definition of the measure is as follows:

- Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2) at the UTSW University Hospitals and Clinics
- This metric will be calculated quarterly for the primary care practice and for each individual provider. The proportion of patients with poor control will be trended and the outcome is to decrease this number by 10% in year 4 and 10% in year 5 if the proportion of patients with a HgbA1c more than 9% is greater than 15%. If the number is less than 15% the outcome metric will be to maintain the number at less than 15%. The milestones are as described in the valuation. A diabetes registry will be developed and data collected for all HgbA1c measurements for all diabetic patients. This registry and data will be validated and the accuracy of the registry and all administrative and clinical data will be checked and improved using a PDCA methodology. Reports will be given to providers at least quarterly

Process and Improvement Milestones

The milestone for this project include

DY2 – establishment of baseline and registry of eligible diabetic patients in the population; Outcome Improvement Targets will be determined in DY2 for DY3 implementation
DY3 – establish treatment protocols and best practices for controlling glucose and test data systems
DY4 – decrease the percent of patients with HgbA1c > 9.0% by 3% from baseline

DY5 - decrease the percent of patients with HgbA1c > 9.0% by 3% from DY4

Data Source: EHR, Registry, Claims, Administrative clinical data

Rationale

Diabetes has been and remains a major cause of morbidity and mortality in the US. It is also one of the most costly and highly prevalent chronic diseases in this country. 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 the disease is 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.

A reliable method of assessing the control of diabetes is periodically measuring the glycosylated hemoglobin (HgbA1c) which provides a reliable estimate of the average glucose of patients over several weeks. Studies have shown that adequate control of diabetes as measured by HgbA1c reduces complications, prevents hospitalizations and prolong life and quality of life. Consequently, developing a system to monitor patients with diabetes with regular assessment of HgbA1c and intervening in those with levels indicating poor control of diabetes will improve the outcomes of these patients. If applied nationally diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

This measure relates to the project in that every institution is trying to improve the care of diabetic patients. The methodology in the course will allow each institution involved to develop performance improvement projects to improve care in all disease categories as well as diabetes. Trained Quality Improvement Champions will reduce costs in whatever institution they practice. We chose this one since it is a universal measure of diabetes control and studies have shown that each diabetic with good control of their blood sugar costs $5-6,000 less to care for than those without good control ($18,000/year vs $12,000/year)

Outcome Measure Valuation

In the rationale for this project, the magnitude of the problem of uncontrolled diabetes was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative and address the medical needs of those patients identified as having a high risk of developing complications. This project is scalable to any size population of diabetic patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from diabetes are prevented and the costs of hospitalization for complications from diabetes can be avoided. In addition, control of diabetes was identified as one of the community priorities in the Community needs assessment.

Related Category 1 or 2 Projects

126686802.2.2: UT Southwestern proposes to design, develop and implement a program that will provide training and education to clinical and administrative staff at various RHP 9 providers on process improvement strategies, methodologies, and culture.

Unique Cat 3 ID: 126686802.3.22	*Reference Number: IT - 1.10*	*Diabetes care: HgbA1c poor control (>9.0%)*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline HgbA1c rates Goal: Establish the baseline for patients aged 18 to 75 years who had HBA1c > 0.9%. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Test reporting accuracy of diabetic registry and ability to detect patients not meeting goal Data Source: EHR and hospital claims data	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities. Goal: Improve registry data, reporting and improvement activities. Data Source: EHR and administrative records **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-1.10]: Improvement Target: Decrease the number of diabetic patients with HgbA1c > 9.0% by 3% percent from baseline Metric: number of patients with diabetes mellitus with poorly controlled diabetes (HgbA1c > 9.0%) Data Source: EHR **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2**[IT-1.10]: Improvement Target: Decrease the number of diabetic patients with HgbA1c > 9.0% by 3% percent from DY4 Metric: number of patients with diabetes mellitus with poorly controlled diabetes (HgbA1c > 9.0%) Data Source: EHR **Outcome Improvement Target 2 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.22	*Reference Number: IT - 1.10*	*Diabetes care: HgbA1c poor control (>9.0%)*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 3 Payment: $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): All cause 30 day readmission rate-NQF 1789 (Standalone measure)

Unique RHP outcome identification number: 126686802.3.23

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-3.1 All cause 30 day readmission rate

This outcome measure will assess the readmission rate with the goal of reducing that rate over time. The definition of the measure will be the following:

Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible Index admission. All readmissions are counted as outcomes except those that are considered planned.

Denominator: This claims-based measure will consist of the following cohorts: admissions to acute care facilities for patients aged 65 years or older who meet the specific diagnosis codes and exclusions in the RHP Planning Protocol at the UTSW University Hospitals.

Process and Improvement Milestones

The milestones for this project will include the following

DY2 – Establish baseline and evaluate the specific causes of readmission for the DRG categories specified; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – develop program specific interventions for categories identified as the cause for readmission
DY4 – reduce readmission rate by 2% from baseline
DY5 – reduce readmission rate by 2% from DY4

Data Source: EHR, Claims

Rationale

Readmissions to the hospital are an important cause of rising health care costs in the US and are widely considered a measure of the overall effectiveness of a health system. Reducing

these rates by transforming the care delivered outside of a hospital will significantly affect the quality of care delivered in the US and decrease costs.

Outcome Measure Valuation

Readmission to the hospital within 30 day markedly increased the cost of health care. Reducing the rate of readmissions by just a few percent will save avoidable costs which were estimated and used in the valuation of this project. This project is a high priority for UT Southwestern.

Related Category 1 or 2 Projects

126686802.2.2: UT Southwestern proposes to design, develop and implement a program that will provide training and education to clinical and administrative staff at various RHP 9 providers on process improvement strategies, methodologies, and culture.

Unique Cat 3 ID: 126686802.3.23	*Reference Number: IT-3.1*	*All cause 30 day readmission rate*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment:** $19,639 **Process Milestone 2** [P-2]: Establish baseline all cause 30 day readmission rate Goal: Establish the baseline for all cause 30 day readmission rate (based on footnote in Attachment I for specific diagnosis codes to be included as well as criteria for case exclusion). Data Source: EHR and claims data **Process Milestone 2 Payment**: $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Develop accurate readmission patient registry and reporting system Data Source: EHR and hospital claims	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities. Goal: Improve readmission patient registry data, reporting and intervention activities. Data Source: EHR and administrative records **Process Milestone 4 Payment:** $68,147 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-3.1]: Improvement Target: Decrease baseline rate of 30 day readmissions by 2% from baseline Description: 30 day all cause readmission rate. To exclude scheduled admissions Data Source: EHR and hospital claims data **Outcome Improvement Target 1 Payment:** $145,803	**Outcome Improvement Target 2** [IT-3.1]: Improvement Target: Decrease rate of 30 day readmissions by 2% from DY4 Description: 30 day all cause readmission rate. To exclude scheduled admissions Data Source: EHR and hospital claims data **Outcome Improvement Target 1 Payment:** $316,623

Unique Cat 3 ID: 126686802.3.23	*Reference Number: IT-3.1*	*All cause 30 day readmission rate*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
data **Process Milestone 3 Payment:** $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (*Standalone measure for Project 2.5)*

Unique RHP outcome identification number: 126686802.3.24

Performing provider name/TPI: The University of Texas Southwestern Medical Center/ TPI 126686802

Outcome Measure Description

I IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (*Standalone measure for Project 2.5)*

The analysis used for this measure will be a Cost of Illness Analysis. The methodology will use the disease registries developed by our analytic team. The individual patients in the registries will be used to develop the cost of illness for episodes of illness and unique patients over time for patients with chronic diseases identified in the planning stage of this Cat 3 project. The disease categories will be selected based on high rates of utilization, costs or financial risk.

Process and Improvement Milestones

Milestone of this project will include:

DY2 – P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3 – P-2 Establish baseline
P- 3 Develop and test data systems
P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

DY4 - IT -5.1 Decrease cost of illness calculation for diseases identified in P-1 by X% from baseline

DY5 - IT -5.1 Decrease cost of illness calculation for diseases identified in P-1 by X% from DY4

Data Source: Planning records, administrative data, cost accounting system

Rationale

Decreasing cost of health care is an important priority of Region 9. An accurate cost accounting system is critical for an institution to be able to reduce costs of care effectively. Global cost of care are not sufficient for the rapid cycle improvements in costs that will be necessary for efficient delivery of care in the future. This project will assess the effectiveness of the cost accounting system as a component of improving efficiency of care delivery by the UT Southwestern Health System

Outcome Measure Valuation

The valuation of this Category 3 project is based on the value of a cost accounting system in the ambulatory setting in setting priorities and driving cost reducing methods of process improvement. Also taken into consideration is the cost of developing such a system

Related Category 1 or 2 Projects

126686802.2.3 Redesigning for Cost Containment

Unique Cat 3 ID: 126686802.3.24	*Reference Number: IT-5.1*	Improved cost savings: Demonstrate cost savings in care delivery (*Standalone measure for Project 2.5)*	
The University of Texas Southwestern Medical Center			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.3*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $58,917	**Process Milestone 2** [P-2]: Establish baseline Goal: Establish the baseline for illness-specific costs of illnesses identified in project description. Data Source: Planning documents and cost accounting system **Process Milestone 2 Payment:** $45,431 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Improve data collection, reporting and analytic functions, survey as well as intervention strategies Data Source: Cost accounting system and administrative data **Process Milestone 3 Payment:** $45,431 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and	**Outcome Improvement Target 1** Improvement Target: IT -5.1 Decrease cost of illness calculation for diseases identified in DY2, Milestone 3, P-6. Baseline: DY3 identified baseline costs in Milestone 2. Goal: Decrease cost by 1% from baseline Data Source: Planning documents and cost accounting system records **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** Improvement Target: IT -5.1 Decrease cost of illness calculation for diseases identified in Milestone 2. Baseline: Costs for targeted diseases in DY4 Goal: Decrease cost by 1% from baseline Data Source: Planning documents and cost accounting system records **Outcome Improvement Target 2 Payment*:*** $ 316,623

Unique Cat 3 ID: 126686802.3.24	*Reference Number: IT-5.1*	Improved cost savings: Demonstrate cost savings in care delivery (*Standalone measure for Project 2.5)*	
The University of Texas Southwestern Medical Center			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.3*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	intervention activities Metric: Number of PDCA improvement cycles Goal: 2 cycles of PDCA Data Source: Planning and improvement data, cost accounting data **Process Milestone 4 Payment:** $45,432		
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): Diabetes care: HgbA1c poor control (>9.0%) NQF 0059 (Standalone Measure)

Unique RHP outcome identification number: 126686802.3.25

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW")/TPI 126686802

Outcome Measure Description

IT-1.10 Diabetes care: HgbA1c poor control (>9.0%)

This measure will assess how well diabetic patients have their blood glucose controlled. The definition of the measure is as follows:

- Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
- This metric will be calculated quarterly for the primary care practice and for each individual provider. The proportion of patients with poor control will be trended and the outcome is to decrease this number by 10% in year 4 and 10% in year 5 if the proportion of patients with a HgbA1c more than 9% is greater than 15%. If the number is less than 15% the outcome metric will be to maintain the number at less than 15%. The milestones are as described in the valuation. A diabetes registry will be developed and data collected for all HgbA1c measurements for all diabetic patients. This registry and data will be validated and the accuracy of the registry and all administrative and clinical data will be checked and improved using a PDCA methodology. Reports will be given to providers at least quarterly

Process and Improvement Milestones

The milestone for this project include

DY2 – establishment of baseline and registry of eligible diabetic patients in the population; Outcome Improvement Targets will be determined in DY2 for DY3 implementation

DY3 – establish treatment protocols and best practices for controlling glucose and test data systems

DY4 – decrease the percent of patients with HgbA1c > 0.9% by TBD

DY5 - decrease the percent of patients with HgbA1c > 0.9% by TBD

Data Source: EHR, Registry, Claims, Administrative clinical data

Rationale

Diabetes has been and remains a major cause of morbidity and mortality in the US. It is also one of the most costly and highly prevalent chronic diseases in this country. 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 the disease is 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.

A reliable method of assessing the control of diabetes is periodically measuring the glycosylated hemoglobin (HgbA1c) which provides a reliable estimate of the average glucose of patients over several weeks. Studies have shown that adequate control of diabetes as measured by HgbA1c reduces complications, prevents hospitalizations and prolong life and quality of life. Consequently, developing a system to monitor patients with diabetes with regular assessment of HgbA1c and intervening in those with levels indicating poor control of diabetes will improve the outcomes of these patients. If applied nationally diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

Outcome Measure Valuation

In the rationale for this project, the magnitude of the problem of uncontrolled diabetes was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative and address the medical needs of those patients identified as having a high risk of developing complications. This project is scalable to any size population of diabetic patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from diabetes are prevented and the costs of hospitalization for complications from diabetes can be avoided. In addition, control of diabetes was identified as one of the community priorities in the Community needs assessment.

Related Category 1 or 2 Projects

126686802.2.4: UT Southwestern proposes to establish a health care navigation program the in UTSCAP Network comprised of care coordinators that provide support to patient populations who are most at risk of receiving disconnected and fragmented care.

Unique Cat 3 ID: 126686802.3.25	*Reference Number: IT - 1.10*	*Diabetes care: HgbA1c poor control (>9.0%)*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.4*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline HgbA1c rates Goal: Establish the baseline for patients aged 18 to 75 years who had HBA1c > 0.9%. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Test reporting accuracy of diabetic registry and ability to detect patients not meeting goal **Process Milestone 3 Payment:** $19,639	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities. Goal: Improve registry data, reporting and improvement activities. Data Source: EHR and administrative records **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-1.10]: Improvement Target: **TBD** Data Source**: TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2**[IT-1.10]: Improvement Target: **TBD** Data Source**: TBD** **Outcome Improvement Target 2 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.25	*Reference Number: IT - 1.10*	*Diabetes care: HgbA1c poor control (>9.0%)*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.4*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): All cause 30 day readmission rate-NQF 1789 (Standalone measure)

Unique RHP outcome identification number: 126686802.3.26

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-3.1 All cause 30 day readmission rate

This outcome measure will assess the readmission rate with the goal of reducing that rate over time. The definition of the measure will be the following:

Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible Index admission. All readmissions are counted as outcomes except those that are considered planned.

Denominator: This claims-based measure will consist of the following cohorts: admissions to acute care facilities for patients aged 65 years or older who meet the specific diagnosis codes and exclusions in the RHP Planning Protocol.

Process and Improvement Milestones

The milestones for this project will include the following

DY2 – Establish baseline and evaluate the specific causes of readmission for the DRG categories specified; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – develop program specific interventions for categories identified as the cause for readmission
DY4 – reduce readmission rate by number **TBD**
DY5 – reduce readmission rate by number **TBD**

Data Source: EHR, Claims

Rationale

Readmissions to the hospital are an important cause of rising health care costs in the US and are widely considered a measure of the overall effectiveness of a health system. Reducing

these rates by transforming the care delivered outside of a hospital will significantly affect the quality of care delivered in the US and decrease costs.

Outcome Measure Valuation

Readmission to the hospital within 30 day markedly increased the cost of health care. Reducing the rate of readmissions by just a few percent will save avoidable costs which were estimated and used in the valuation of this project. This project is a high priority for UT Southwestern.

Related Category 1 or 2 Projects

126686802.2.4: UT Southwestern proposes to establish a health care navigation program the in UTSCAP Network comprised of care coordinators that provide support to patient populations who are most at risk of receiving disconnected and fragmented care.

Unique Cat 3 ID: 126686802.3.26	*Reference Number: IT-3.1*	*All cause 30 day readmission rate*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.4*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment:** $19,639 **Process Milestone 2** [P-2]: Establish baseline all cause 30 day readmission rate Goal: Establish the baseline for all cause 30 day readmission rate (based on footnote in Attachment I for specific diagnosis codes to be included as well as criteria for case exclusion). Data Source: EHR and claims data **Process Milestone 2 Payment**: $19,639 **Process Milestone 3:** Develop and test data systems; Goal: Develop accurate readmission	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities. Goal: Improve readmission patient registry data, reporting and intervention activities. Data Source: EHR **and administrative records** **Process Milestone 4 Payment:** $68,147 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-3.1]: Improvement Target: **Outcome** Decrease baseline rate of 30 day readmissions to number **TBD** Data Source**:** EHR, Hospital admissions data; claims data. **Outcome Improvement Target 1 Payment:** $145,803	**Outcome Improvement Target 2** [IT-3.1]: Improvement Target: Decrease baseline rate of 30 day readmissions to **TBD** Data Source**:** EHR, Hospital admissions data; claims data. **Outcome Improvement Target 1 Payment:** $316,623

Unique Cat 3 ID: 126686802.3.26	*Reference Number: IT-3.1*	*All cause 30 day readmission rate*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.4*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
patient registry and reporting system Data Source: Registry reports. **Process Milestone 3 Payment:** $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): Diabetes care: HgbA1c poor control (>9.0%) NQF 0059 (Standalone Measure)

Unique RHP outcome identification number 126686802.3.27

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW")/TPI 126686802

Outcome Measure Description

IT-1.10 Diabetes care: HgbA1c poor control (>9.0%)

This measure will assess how well diabetic patients have their blood glucose controlled. The definition of the measure is as follows:

- Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
- This metric will be calculated quarterly for the primary care practice and for each individual provider. The proportion of patients with poor control will be trended and the outcome is to decrease this number by 10% in year 4 and 10% in year 5 if the proportion of patients with a HgbA1c more than 9% is greater than 15%. If the number is less than 15% the outcome metric will be to maintain the number at less than 15%. The milestones are as described in the valuation. A diabetes registry will be developed and data collected for all HgbA1c measurements for all diabetic patients. This registry and data will be validated and the accuracy of the registry and all administrative and clinical data will be checked and improved using a PDCA methodology. Reports will be given to providers at least quarterly

Process and Improvement Milestones

The milestone for this project include

DY2 – establishment of baseline and registry of eligible diabetic patients in the population; Outcome Improvement Targets will be determined in DY2 for DY3 implementation
DY3 – establish treatment protocols and best practices for controlling glucose and test data systems
DY4 – decrease the percent of patients with HgbA1c > 0.9% by TBD
DY5 - decrease the percent of patients with HgbA1c > 0.9% by TBD

Data Source: EHR, Registry, Claims, Administrative clinical data

Rationale

Diabetes has been and remains a major cause of morbidity and mortality in the US. It is also one of the most costly and highly prevalent chronic diseases in this country. 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 the disease is 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.

A reliable method of assessing the control of diabetes is periodically measuring the glycosylated hemoglobin (HgbA1c) which provides a reliable estimate of the average glucose of patients over several weeks. Studies have shown that adequate control of diabetes as measured by HgbA1c reduces complications, prevents hospitalizations and prolong life and quality of life. Consequently, developing a system to monitor patients with diabetes with regular assessment of HgbA1c and intervening in those with levels indicating poor control of diabetes will improve the outcomes of these patients. If applied nationally diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

Outcome Measure Valuation

In the rationale for this project, the magnitude of the problem of uncontrolled diabetes was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative and address the medical needs of those patients identified as having a high risk of developing complications. This project is scalable to any size population of diabetic patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from diabetes are prevented and the costs of hospitalization for complications from diabetes can be avoided. In addition, control of diabetes was identified as one of the community priorities in the Community needs assessment.

Related Category 1 or 2 Projects

126686802.2.5: UT Southwestern proposes to establish a health care navigation program the in UTSCAP Network comprised of care coordinators that provide support to patient populations who are most at risk of receiving disconnected and fragmented care.

Unique Cat 3 ID: 126686802.3.27	*Reference Number: IT - 1.10*	*Diabetes care: HgbA1c poor control (>9.0%)*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.5*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline HgbA1c rates Goal: Establish the baseline for patients aged 18 to 75 years who had HBA1c > 0.9%. Data Source: EHR and claims data **Process Milestone 2 Payment:** $19,639 **Process Milestone 3 [P-3}:** Develop and test data systems; Goal: Test reporting accuracy of diabetic registry and ability to detect patients not meeting goal	**Process Milestone 4 [P-4]:** Conduct PDSA cycles to improve data collection and intervention activities. Goal: Improve registry data, reporting and improvement activities. Data Source: EHR and administrative records **Process Milestone 4 Payment:** $68,147 **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-1.10]: Improvement Target: **TBD** **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-1.10]: Improvement Target: **TBD** **Outcome Improvement Target 2 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.27	*Reference Number: IT - 1.10*	*Diabetes care: HgbA1c poor control (>9.0%)*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.5*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 3 Payment: $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $657,637			

Title of Outcome Measure (Improvement Target): All cause 30 day readmission rate-NQF 1789 (Standalone measure)

Unique RHP outcome identification number: 126686802.3.28

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-3.1 All cause 30 day readmission rate

This outcome measure will assess the readmission rate with the goal of reducing that rate over time. The definition of the measure will be the following:

Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible Index admission. All readmissions are counted as outcomes except those that are considered planned.

Denominator: This claims-based measure will consist of the following cohorts: admissions to acute care facilities for patients aged 65 years or older who meet the specific diagnosis codes and exclusions in the RHP Planning Protocol.

Process and Improvement Milestones

The milestones for this project will include the following

DY2 – Establish baseline and evaluate the specific causes of readmission for the DRG categories specified; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – develop program specific interventions for categories identified as the cause for readmission
DY4 – reduce readmission rate by number **TBD**
DY5 – reduce readmission rate by number **TBD**

Data Source: EHR, Claims

Rationale

Readmissions to the hospital are an important cause of rising health care costs in the US and are widely considered a measure of the overall effectiveness of a health system. Reducing

these rates by transforming the care delivered outside of a hospital will significantly affect the quality of care delivered in the US and decrease costs.

Outcome Measure Valuation

Readmission to the hospital within 30 day markedly increased the cost of health care. Reducing the rate of readmissions by just a few percent will save avoidable costs which were estimated and used in the valuation of this project. This project is a high priority for UT Southwestern.

Related Category 1 or 2 Projects

126686802.2.5: UT Southwestern proposes to develop, implement and evaluate standardized protocols and evidence-based care delivery model through a network of post-acute care providers and community organizations to improve care delivered to people during transitions of care.

Unique Cat 3 ID: 126686802.3.28	*Reference Number: IT-3.1*	*All cause 30 day readmission rate*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.5*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $19,639 **Process Milestone 2** [P-2]: Establish baseline all cause 30 day readmission rate Goal: Establish the baseline for all cause 30 day readmission rate (based on footnote in Attachment I for specific diagnosis codes to be included as well as criteria for case exclusion). Data Source: EHR and claims data **Process Milestone 2 Payment**: $19,639 **Process Milestone 3 [P-3]:** Develop and test data systems; Goal: Develop accurate readmission patient registry and reporting system Data Source: EHR, Claims data, Registry reports	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities. Goal: Improve readmission patient registry data, reporting and intervention activities. Data Source: EHR **and administrative records** **Process Milestone 4 Payment:** $68,147 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $68,147	**Outcome Improvement Target 1** [IT-3.1]: Improvement Target: **Outcome** Decrease baseline rate of 30 day readmissions to number **TBD** Data Source: EHR, Claims data **Outcome Improvement Target 1 Payment*:*** $145,803	**Outcome Improvement Target 2** [IT-3.1]: Improvement Target: Decrease baseline rate of 30 day readmissions to **TBD** Data Source: EHR, Claims data **Outcome Improvement Target 1 Payment*:*** $316,623

Unique Cat 3 ID: 126686802.3.28	*Reference Number: IT-3.1*	*All cause 30 day readmission rate*	
The University of Texas Southwestern Medical Center – Faculty Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.2.5*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 3 Payment: $19,639			
Year 2 Estimated Outcome Amount: $58,917	**Year 3 Estimated Outcome Amount:** $136,294	**Year 4 Estimated Outcome Amount:** $145,803	**Year 5 Estimated Outcome Amount:** $316,623
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $657,637			

Title of Outcome Measure (Improvement Target): IT-1.20 Educated Primary Care Workforce

Unique RHP outcome identification number: 126686802.3.29

Performing provider name/TPI: The University of Texas Southwestern Medical Center/ TPI 126686802

Outcome Measure Description

IT-1.20 Number of primary care practitioners in HPSAs or MUAs who report they plan to implement chronic disease management. A survey will be developed and validated to measure this metric in primary care providers participating in the CME project noted below

Process and Improvement Milestones

Milestone of this project will include:

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
P- 3 Develop and test data systems
DY4 - IT- 20.1 Increase the number of primary care physicians who report the plan to use chronic disease management by X (TBD) over baseline year
DY5 - IT- 20.1 Increase the number of primary care physicians who report the plan to use chronic disease management by X (TBD) over DY4

Data Source: Survey data and administrative data

Rationale

Chronic disease management strategies are known to decrease costs by decreasing hospitalization and utilization of other resources. Physicians and other providers need to be trained in the chronic disease management strategies to be effective. This outcome measure will provide an assessment of the success of those educational strategies.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses chronic disease management strategies in the care of patients with certain chronic diseases. This project will use a registry to identify patients, analyze clinical and administrative data and address the medical needs of those patients identified as having a chronic disease that is amenable to a chronic disease management plan. The populations served will be primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from

chronic disease are common and the costs of hospitalization for these complications can be avoided.

Related Category 1 or 2 Projects

126686802.1.7 CME Courses

Unique Cat 3 ID: 126686802.3.29	*Reference Number: IT-1.20*	Educated Primary Care Workforce	
The University of Texas Southwestern Medical Center			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.7*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $89,603	**Process Milestone 2** [P-2]: Establish baseline Goal: Establish the baseline for primary care physicians Data Source: Survey results **Process Milestone 2 Payment:** $98,495 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Improve data collection, reporting and analytic functions, survey as well as intervention strategies Data Source: survey data and administrative records **Process Milestone 3 Payment:** $98,495	**Outcome Improvement Target 1** [IT-20.1]: Improvement Target: Increase the number of primary care physicians who report the plan to use chronic disease management by X (TBD) over baseline year Data Source: Survey data and administrative records **Outcome Improvement Target 1 Payment*:*** $268,810	**Outcome Improvement Target 2** [IT-20.1]: Improvement Target**:** Increase the number of primary care physicians who report the plan to use chronic disease management by X (TBD) over DY4 Data Source: Survey and administrative records **Outcome Improvement Target 2 Payment*:*** $580,887
Year 2 Estimated Outcome Amount: $89,603	**Year 3 Estimated Outcome Amount:** $196,990	**Year 4 Estimated Outcome Amount:** $268,810	**Year 5 Estimated Outcome Amount:** $580,887
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,136,290			

Title of Outcome Measure (Improvement Target): IT-14.2 Number of practicing nurse practitioners and physician assistant per 1000 individuals in HPSAs or MUAs

Unique RHP outcome identification number: 126686802.3.30

Performing provider name/TPI: The University of Texas Southwestern Medical Center/ TPI 126686802

Outcome Measure Description

IT-14.1 Number of practicing primary care practitioners per 1000 individuals in HPSAs or MUAs. The goal is to increase the number of primary care practitioners by education to family practice residents
on the concepts and advantages of the Patient-Center medical Home (PCMH). This outcome is important to address the need of more primary care physicians for Texas

Process and Improvement Milestones

Milestone of this project will include:

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
P- 3 Develop and test data systems
DY4 - IT- 14.1 Increase the number of practicing primary care practitioners per 1000 individuals in HPSAs or MUAs by X (TBD) over baseline
DY5 - IT- 14.1 Increase the number of practicing primary care practitioners per 1000 individuals in HPSAs or MUAs by X (TBD) over DY4

Data Source: HR data and administrative data

Rationale

The need for primary care practitioners is well documented in the Community Needs Assessment nd from the literature. One method of promoting primary care has been to introduce the Patient-Centered Medical Home as a delivery model to make primary care more attractive to trainees. This ourcome measurement will be used to assess the success of that project and strategy.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that promotes the benefits of practicing in a primary care setting. This project provide great

benefit to patients of primary care practices who use the concepts and principles of the Patient-Centered Medical Home (PCMH). The populations served will be primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project as well as the patients of our Family Medicine resident clinic. The community benefit is obvious as the primary care work force is increased..

Related Category 1 or 2 Projects

126686802.1.8 Family Medicine Residency Courses on PCMH

Unique Cat 3 ID: 126686802.3.30	*Reference Number: IT-14.1*	Number of practicing primary care practitioners per 1000 individuals in HPSAs or MUAs	
The University of Texas Southwestern Medical Center			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.8*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $59,801	**Process Milestone 2** [P-2]: Establish baseline Goal: Establish the baseline for primary care physicians Data Source: HR and administrative records **Process Milestone 2 Payment:** $72,336 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Improve data collection, reporting and analytic functions, survey as well as intervention strategies Data Source: HR and administrative records **Process Milestone 3 Payment:** $72,336	**Outcome Improvement Target 1** [IT-14.1]: Improvement Target: **Outcome** Increase the number of practicing primary care practitioners per 1000 individuals in HPSAs or MUAs by X (TBD) over baseline Data Source: HR data and administrative records **Outcome Improvement Target 1 Payment*:*** $245,751	**Outcome Improvement Target 2** [IT-14.1]: Improvement Target**: Outcome** Increase the number of practicing primary care practitioners per 1000 individuals in HPSAs or MUAs by X (TBD) over baseline Data Source: HR data and administrative records **Outcome Improvement Target 2 Payment*:*** $387,683
Year 2 Estimated Outcome Amount: $59,801	**Year 3 Estimated Outcome Amount:** $144,671	**Year 4 Estimated Outcome Amount:** $245,751	**Year 5 Estimated Outcome Amount:** $387,683
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $837,906			

Title of Outcome Measures (Improvement Target): (IT-14.2) Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs

Unique RHP outcome identification number: 126686802.3.31

Performing provider: UT Southwestern Medical Center Practice Plan/126686802

Outcome Measure Description:
IT-14.2 Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs (*Standalone measure*)

This outcome measure will support a project that significantly increases the size of the physician assistant training program at UT Southwestern Medical Center. The purpose of this measure is to assess the effectiveness of this program in placing graduates in HPSAs or MUAs.

Rationale: This measure is needed to assess the effectiveness of the UTSW physician assistant training program in supporting the community goal of increasing the number of primary care providers serving Medicaid or other medically underserved populations. Since the increase in graduates will not be immediate, the outcomes will not be seen immediately.

DY2

Milestone(s): P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3

Milestone(s): P-2 Establish baseline rates

DY4

IT-14.2 Outcome improvement target – increase the number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs by X% over baseline.

DY5

IT-14.2 Outcome improvement target – increase the number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs by X% over DY4.

Outcome Measure Valuation: The valuation of this project outcome was based on the cost of training of physician assistant students and the benefit to Region 9 patients of having increased number of physician assistants providing primary or other care to underserved populations. Because the benefit will be after increased number of trainees matriculate, most of the valuation is in year DY4 and DY5.

Related Category 1 or 2 Projects

126686802.1.9 Expansion of Physician Assistant Program

Process Milestones/Outcome Improvement Targets Table for each Category 3

126686802.3.31	*IT-14.2*	Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs (*Standalone measure*)	
UT Southwestern medical Center Faculty Practice Plan			*126686802*
Related Category 1 or 2 Projects:	126686802.1.9		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: complete plan Data Source: PA program administrative records and survey results Process Milestone 1 Estimated Incentive Payment*:* $110,087	**Process Milestone 2 [P-2]** Establish baseline rates Data Source: PA program administrative records and survey results Metric 2: establish baseline Process Milestone 2 Estimated Incentive Payment: $241,778	**Outcome Improvement Target 1** Improvement Target: increase the number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs by X% over baseline (TBD). Data Source: PA program administrative records Outcome Improvement Target 1 Estimated Incentive Payment*:* $366,416	**Outcome Improvement Target 2**: Improvement Target: increase the number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs by X% over DY4 (TBD). Data Source: PA program administrative records Outcome Improvement Target 2 Estimated Incentive Payment*:* $713,684
Year 2 Estimated Outcome Amount: $110,087	Year 3 Estimated Outcome Amount: $241,778	Year 4 Estimated Outcome Amount: $366,416	Year 5 Estimated Outcome Amount: $713,684
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,431,965			

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Title of Outcome Measure (Improvement Target): Controlling high blood pressure NCQA-HEDIS 2012, NQF 0018 (Standalone Measure)

Unique RHP outcome identification number: 126686802.3.32

Performing provider name/TPI: The University of Texas Southwestern Medical Center ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-1.7 Controlling high blood pressure

This measure will assess the number of patients with hypertension who have their blood pressure controlled to at least 140/90 during the measurement year. The measure will be defined as:

Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year

Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension

Process and Improvement Milestones

Milestone of this project will include:

DY2 – assessment of baseline percent of patients controlled of study population and establishment of hypertension registry; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – increase the percent of patients with adequate hypertension control by **TBD**
DY4 - increase the percent of patients with adequate hypertension control by **TBD**
DY5 - increase the percent of patients with adequate hypertension control by **TBD**

Data Source: EHR, Claims

Rationale

Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensive patients, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates

that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee.

Outcome Measure Valuation

In the rationale for this project, the magnitude of the problem of uncontrolled hypertension was addressed. The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative and address the medical needs of those patients identified as having a high risk of developing complications. This project is scalable to any size population of hypertensive patients. The populations served will be the primary care patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from hypertension are prevented and the costs of hospitalization for complications from hypertension can be avoided. In addition, control of hypertension was identified as one of the community priorities in the Community needs assessment.

Related Category 1 or 2 Projects

- 126686802.1.10—Training of Community Health Workers (CHWs)

Unique Cat 3 ID: 126686802.3.32	*Reference Number: IT-1.7*	*Controlling high blood pressure*	
The University of Texas Southwestern Medical Center			*TPI 126686802*
Related Category 1 or 2 Projects:	126686802.1.10		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment:** $29,880 **Process Milestone 2** [P-2]: Establish baseline blood pressure control rates rates Goal: Establish the baseline for patients aged 18 to 85 years whose most recent BP is adequately controlled (BP < 140/90 mm). Data Source: EHR and claims data **Process Milestone 2 Payment:** $29,880 **Process Milestone 3:** Develop and test data systems; Goal: Develop capability to collect, analyze and report clinical and administrative data to support project **Process Milestone 3 Payment:** $29,880	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities Goal: Improve data collection, reporting and analytic functions as well as intervention strategies Data Source: EHR and administrative records **Process Milestone 4 Payment:** $108,332 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $108,332	**Outcome Improvement Target 1** [IT-1.7]: Improvement Target: **Outcome** Improve blood pressure control by **TBD** **Outcome Improvement Target 1 Payment:** $219,903	**Outcome Improvement Target 2** [IT-1.7]: Improvement Target**: Outcome** Improve blood pressure control by **TBD** **Outcome Improvement Target 1 Payment:** $587,959

Unique Cat 3 ID: 126686802.3.32	*Reference Number: IT-1.7*	*Controlling high blood pressure*	
The University of Texas Southwestern Medical Center			*TPI 126686802*
Related Category 1 or 2 Projects:	126686802.1.10		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $89,642	**Year 3 Estimated Outcome Amount:** $216,664	**Year 4 Estimated Outcome Amount:** $219,903	**Year 5 Estimated Outcome Amount:** $587,959
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,114,168			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization *(Standalone measure)*

Unique RHP outcome identification number: 126686802.3.33

Performing provider name/TPI: The University of Texas Southwestern Medical Center/ TPI 126686802

Outcome Measure Description

IT-9.2 ED appropriate utilization *(Standalone measure)*

Reduce Emergency Department visits for target conditions. Provider has chosen cancer patient

Data Source: EHR, Claims

Process and Improvement Milestones

Milestone of this project will include:

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
P- 3 Develop and test data systems

DY4 - IT- 9.2 Decrease the number of ER visits for cancer patients follow in the Simmons Comprehensive Cancer Center by X (TBD) from baseline

DY5 - IT- 9.2 Decrease the number of ER visits for cancer patients follow in the Simmons Comprehensive Cancer Center by X (TBD) from DY4

Data Source: EHR, Claims

Rationale

Patients being treated for cancer have many complications from their disease and from the treatment. Treatment for non-emergent conditions that arise in cancer patients should be carried out in the outpatient setting whenever possible to reduce the risk of hospital acquired conditions and reduce the cost of care. This outcome measure will assess the effectiveness of an urgent care system for cancer patients on ER utilization.

Outcome Measure Valuation

The valuation of the milestones includes reduced costs and potential benefits of developing a system that reduces emergency room visits for cancer patients with urgent but no emergent medical needs. We will use a cancer registry to identify cancer patients, analyze clinical and administrative data and address the medical needs of those patients identified as having a high risk of needing urgent care because of their cancer and its treatment. The populations served will be oncology patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications

from cancer treatment are common and the costs of emergency department visits for these complications can be avoided as well as the added risk immune-suppressed patient have with visiting an emergency room.

Related Category 1 or 2 Projects

175287501.2.3 Transitional Care for Cancer Patients
126686802.1.11 Oncology Urgent Care Services
175287501.2.2 Palliative Care

Unique Cat 3 ID: 126686802.3.33	*Reference Number: IT-9.2*	ED appropriate utilization *(Standalone measure)*	
The University of Texas Southwestern Medical Center			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.11*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $63,961	**Process Milestone 2** [P-2]: Establish baseline cancer patient ED visits Goal: Establish the baseline for patients aged 18 and over with cancer Data Source: EHR and claims data **Process Milestone 2 Payment:** $83,424 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Improve data collection, reporting and analytic functions as well as intervention strategies Data Source: EHR and administrative records **Process Milestone 3 Payment:** $83,424	**Outcome Improvement Target 1** [IT-9.2]: Improvement Target: **Outcome** Decrease emergency department visits for target population by X (TBD) from baseline Data Source: EHR and administrative records **Outcome Improvement Target 1 Payment*:*** $289,643	**Outcome Improvement Target 2** [IT-9.2]: Improvement Target**: Outcome** Decrease emergency department visits for target population by X (TBD) from DY4 Data Source: EHR and administrative records **Outcome Improvement Target 2 Payment*:*** $918,191
Year 2 Estimated Outcome Amount: $63,961	**Year 3 Estimated Outcome Amount:** $166,848	**Year 4 Estimated Outcome Amount:** $289,643	**Year 5 Estimated Outcome Amount:** $918,191
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,438,643			

Title of Outcome Measure (Improvement Target): IT 2.13 Other Admissions Rate (Cancer) *(Standalone measure)*

Unique RHP outcome identification number: 126686802.3.34

Performing provider name/TPI: The University of Texas Southwestern Medical Center/ TPI 126686802

Outcome Measure Description

IT 2.13 Other Admissions Rate (Cancer) *(Standalone measure).* The provider has chosen cancer patients with complications of cancer treatment for this admission measure

Numerator: Number of admissions for complications of cancer treatment in patients 18 years or older

Denominator: Number of cancer patients 18 years old or greater in UTSW faculty practice who are being treated for cancer.

Data Source: EHR, Claims

Process and Improvement Milestones

Milestone of this project will include:

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
P- 3 Develop and test data systems
DY4 - IT- 3.13 Decrease the admission rate for patients with cancer with treatment related complications by X% (TBD) from baseline
DY5 - IT- 3.13 Decrease the admission rate for patients with cancer with treatment related complications by X% (TBD) from DY4

Data Source: EHR, Claims

Rationale

The relationship between hospital admission rates and quality of care is well-documented and may relate to complications from cancer treatment rather than the cancer itself. Cancer patients in particular have high treatment complication rates and hospitalization for those complications puts these immune-suppressed patients at high risk for hospital acquired infections. It is important to decrease this cause of admission to improve cancer patient's quality of life and survival overall.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify cancer patients, analyze clinical and administrative data and address the medical needs of those patients identified as having a high risk of developing complications of cancer and its treatment. The populations served will be oncology patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from cancer treatment are common and the costs of hospitalization for these complications can be avoided as well as the added risk immune-suppressed patient have with hospitalization

Related Category 1 or 2 Projects

175287501.2.3 Transitional Care for Cancer Patients
126686802.1.11 Oncology Urgent Care Services
175287501.2.2 Palliative Care

Unique Cat 3 ID: 126686802.3.34	*Reference Number: IT-2.13*	Other Admissions Rate (Cancer) *(Standalone measure)*	
The University of Texas Southwestern Medical Center			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.11*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $63,961	**Process Milestone 2** [P-2]: Establish baseline cancer treatment complication admission rates Goal: Establish the baseline for patients aged 18 and over Data Source: EHR and claims data **Process Milestone 2 Payment:** $83,424 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Improve data collection, reporting and analytic functions as well as intervention strategies Data Source: EHR and administrative records **Process Milestone 3 Payment:** $83,424	**Outcome Improvement Target 1** [IT-3.12]: Improvement Target: **Outcome** Decrease admission rate for target population by X% (TBD) from baseline Data Source: EHR and administrative records **Outcome Improvement Target 1 Payment*:*** $289,643	**Outcome Improvement Target 2** [IT-3.12]: Improvement Target**: Outcome** Decrease admission rate for target population by X% (TBD) from DY4 Data Source: EHR and administrative records **Outcome Improvement Target 2 Payment*:*** $918,191
Year 2 Estimated Outcome Amount: $63,961	**Year 3 Estimated Outcome Amount:** $166,848	**Year 4 Estimated Outcome Amount:** $289,643	**Year 5 Estimated Outcome Amount:** $918,191
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,438,643			

Title of Outcome Measure (Improvement Target): All cause 30 day readmission rate-NQF 1789 (Standalone measure)

Unique RHP outcome identification number: 126686802.3.35

Performing provider name/TPI: The University of Texas Southwestern Medical Center - Faculty Practice Plan ("UT Southwestern" or "UTSW"/TPI 126686802

Outcome Measure Description

IT-3.1 All cause 30 day readmission rate

This outcome measure will assess the readmission rate with the goal of reducing that rate over time. The definition of the measure will be the following:

Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible Index admission. All readmissions are counted as outcomes except those that are considered planned.
Denominator: This claims-based measure will consist of the following cohorts: admissions to acute care facilities for patients aged 65 years or older who meet the specific diagnosis codes and exclusions in the RHP Planning Protocol.

Process and Improvement Milestones

The milestones for this project will include the following

DY2 – Establish baseline and evaluate the specific causes of readmission for the DRG categories specified; Outcome Improvement Targets will be determined in DY2 for DY3 implementation.
DY3 – develop program specific interventions for categories identified as the cause for readmission
DY4 – reduce readmission rate by number **TBD**
DY5 – reduce readmission rate by number **TBD**

Data Source: EHR, Claims

Rationale

Readmissions to the hospital are an important cause of rising health care costs in the US and are widely considered a measure of the overall effectiveness of a health system. Reducing these rates by transforming the care delivered outside of a hospital will significantly affect the quality of care delivered in the US and decrease costs.

Outcome Measure Valuation

Readmission to the hospital within 30 day markedly increased the cost of health care. Reducing the rate of readmissions by just a few percent will save avoidable costs which were estimated and used in the valuation of this project. This project is a high priority for UT Southwestern.

Related Category 1 or 2 Projects

126686802.1.12: UT Southwestern proposes to design, develop and implement a program that will provide training and expertise to clinical and administrative staff at UTSW in process re-engineering and process improvement.

126686802.3.35	*IT-3.1*	*All cause 30 day readmission rate*	
The University of Texas Southwestern Medical Center – Faculty Practice Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.12*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment:** $43,511 **Process Milestone 2** [P-2]: Establish baseline all cause 30 day readmission rate Goal: Establish the baseline for all cause 30 day readmission rate (based on footnote in Attachment I for specific diagnosis codes to be included as well as criteria for case exclusion). Data Source: EHR and claims data **Process Milestone 2 Payment**: $43,511 **Process Milestone 3:** Develop and test data systems; Goal: Develop accurate readmission patient registry and reporting system Data source: EHR and claims data	**Process Milestone 4** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities. Goal: Improve readmission patient registry data, reporting and intervention activities. Data Source: EHR and administrative records **Process Milestone 4 Payment:** $143,340 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Goal: Disseminate findings and educate stakeholders on findings. Data Source: Meeting Minutes and documentation of "lessons learned" and best-practices **Process Milestone 5 Payment:** $143,340	**Outcome Improvement Target 1** [IT-3.1]: Improvement Target: Decrease baseline rate of 30 day readmissions to number **TBD** Data Source: EHR and claims data **Outcome Improvement Target 1 Payment:** $434,465	**Outcome Improvement Target 2** [IT-3.1]: Improvement Target: Decrease baseline rate of 30 day readmissions to **TBD** Data Source: EHR and claims data **Outcome Improvement Target 1 Payment:** $828,605

126686802.3.35	*IT-3.1*	*All cause 30 day readmission rate*	
The University of Texas Southwestern Medical Center – Faculty Practice Plan			*TPI 126686802*
Related Category 1 or 2 Projects:	*126686802.1.12*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 3 Payment: $43,510			
Year 2 Estimated Outcome Amount: $130,532	**Year 3 Estimated Outcome Amount:** $286,680	**Year 4 Estimated Outcome Amount:** $434,465	**Year 5 Estimated Outcome Amount:** $828,605
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,680,282			

Title of Outcome Measure (Improvement Target): IT-3.12 Other - readmission rate (Medication complications) *(Standalone measure)*

Unique RHP outcome identification number: 126686802.3.36

Performing provider name/TPI: The University of Texas Southwestern Medical Center/ TPI 126686802

Outcome Measure Description

IT-3.12 Other - readmission rate [*To be selected by provider*] *(Standalone measure).* The provider chooses complications of medications readmissions for this readmission project.

Numerator: The number of readmissions (for patients 18 years and older) for complications of medications from the index admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with any diagnosis and with a complete claims history for the 12 months prior to admission.

Process and Improvement Milestones

Milestone of this project will include:

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
P- 3 Develop and test data systems
DY4 - IT- 3.12 Decrease the readmission rate for patients with complications from medication by X% (TBD) from baseline
DY5 - IT- 3.12 Decrease the readmission rate for patients with complications from medications by X% (TBD) from DY4

Data Source: EHR, Claims

Rationale

The relationship between hospital readmission rates and quality of care is well-documented. Some readmissions are caused from medication complications from the index admissions or from circumstances surrounding the initial hospital stay. Patients who take a large number of medications in particular have high hospital readmission rates and high rates are considered by

some as an indication of weakness in the overall care of patients with a particular condition. Only readmissions to the same facility will be included as part of each hospital's rates.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative and address the medical needs of those patients identified as having a high risk of developing complications of medications. The populations served will be al patients admitted to UT Southwestern University Hospitals and seen UT Southwestern clinics. The community benefit is obvious as complications from medication treatment are common and the costs of hospitalization for these complications can be avoided.

Related Category 1 or 2 Projects

126686802.2.6 Conduct medication management

126686802.3.36	*IT-3.12*	Other - readmission rate (Medication complications) *(Standalone measure)*	
The University of Texas Southwestern Medical Center			*126686802*
Related Category 1 or 2 Projects:	*126686802.2.6*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $80,247	**Process Milestone 2** [P-2]: Establish baseline cancer readmission rates Goal: Establish the baseline for patients aged 18 and over Data Source: EHR and claims data **Process Milestone 2 Payment:** $132,180 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Improve data collection, reporting and analytic functions as well as intervention strategies Data Source: EHR and administrative records **Process Milestone 3 Payment:** $132,180	**Outcome Improvement Target 1** [IT-3.12]: Improvement Target: **Outcome** Decrease readmission rate for cancer patient by X% (TBD) from baseline Data Source: EHR and administrative records **Outcome Improvement Target 1 Payment*:*** $587,601	**Outcome Improvement Target 2** [IT-3.12]: Improvement Target**: Outcome** Decrease readmission rate for cancer patient by X% (TBD) from DY4 Data Source: EHR and administrative records **Outcome Improvement Target 2 Payment*:*** $1,528,569
Year 2 Estimated Outcome Amount: $80,247	Year 3 Estimated Outcome Amount: $264,360	Year 4 Estimated Outcome Amount: $587,601	Year 5 Estimated Outcome Amount: $1,528,569
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,460,777			

Title of Outcome Measures (Improvement Target): IT-1.20: Other outcomes improvement target. Outcomes of bone marrow and solid organ transplantation.

Unique RHP outcomes identification number: 175287501.3.1

Performing provider: The University of Texas Southwestern University Hospitals/ 175287501

Outcome Measure Description

IT-1.20: Other Outcome

This measure will examine the 1 year survival of patients who get a bone marrow or solid organ transplant. The percentage will be compared with established national and regional metrics. The definition of the measure will be as follows:

Numerator: number of patients alive at the one year anniversary of their transplant.
Denominator: Number of eligible patients transplanted
The metric will then be compared to national metrics for each type of transplant.

Process and Improvement Milestones

The milestones for this project will be as follows:

DY2 – establish mechanism of obtaining referrals of underfunded medically eligible patients.
DY3 – evaluate eligible patients for transplant suitability and if eligible, list patient for appropriate transplant
DY4 – 10 underfunded patients will be listed. Transplanted patients will have 1 year mortality equal to regional average using 95% confidence interval
DY5 – 20 underfunded patients will be listed. Transplanted patients will have 1 year mortality equal to regional average using 95% confidence interval

Rationale

The goal of this project is to address a major disparity in access to specialty care for patients with inadequate funding. That disparity involves the availability of bone marrow and solid organ transplantation. Despite contributing significantly to the donation of organs and tissue for transplantation, these patients do not, many times, receive these life-saving procedures because of a lack of adequate funding.

UT Southwestern is a nationally recognized center for solid organ and bone marrow transplantation services and has outcomes for these services that rank in the top tier of the United States. Currently, indigent and Medicaid patients are less likely to receive needed bone marrow, heart, lung and liver transplants when compared to matched patients with funding through Medicare or commercial insurance. We propose a program to address this disparity by offering these transplant services to medically eligible patients through our current transplant programs.

Outcome Measure Valuation:
The valuation of this project is based on the potential benefit these patients will receive from the needed transplant and the cost of providing the evaluation, transplant itself and related post-transplant care. These services are currently provided to patients with adequate funding and the delta between the cost of providing the care and benefit enjoyed by the underfunded patients. This project will address a significant disparity in care between funded patients and underfunded patients.

Related Category 1 or 2 Projects
175287501.1.1—Expanding specialty care capacity by providing access to bone marrow and solid organ transplants for patients with inadequate funding.

Unique Cat 3 ID: 175287501.3.1	*Reference Number: IT-1.20*	*Outcomes of bone marrow and solid organ transplantation*	
The University of Texas Southwestern University Hospitals			*TPI 175287501*
Related Category 1 or 2 Projects:	*175287501.1.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Establish mechanism of obtaining referrals of underfunded medically eligible patients. Improvement target: Report Data Source: Administrative records of transplant center Process Milestone 1 Estimated Incentive Payment*:* $178,694	**Process Milestone 2** P-2 evaluate eligible patients for transplant suitability and if eligible, list patient for appropriate transplant Improvement target: TBD Data Source: EHR and administrative records of center Process Milestone 2 Estimated Incentive Payment: $207,130	**Outcome Improvement Target 1** Transplanted patients will have 1 year mortality equal to regional average using 95% confidence interval Data Source: EHR and transplant center records Outcome Improvement Target 1 Estimated Incentive Payment*:* $332,372	**Outcome Improvement Target 2** Transplanted patients will have 1 year mortality equal to regional average using 95% confidence interval Data Source: EHR and transplant center records Outcome Improvement Target 3 Estimated Incentive Payment*:* $794,802
Year 2 Estimated Outcome Amount: $178,694	Year 3 Estimated Outcome Amount: $207,130	Year 4 Estimated Outcome Amount: $332,372	Year 5 Estimated Outcome Amount: $794,802
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,512,999			

Title of Outcome Measure (Improvement Target): IT-2.12: Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions *(Standalone measure)*

Unique RHP outcome identification number: 1752287501.3.2

Performing provider name/TPI: The University of Texas Southwestern University Hospitals/TPI 175287501

Outcome Measure Description

Numerator: Composites are constructed by summing the hospitalizations across the component conditions and dividing by the population. Rates can optionally be adjusted for age, sex and socio-economic status when comparing across regions or demographic groups.

Data Source: EHR, Claims

Rationale/Evidence: An overall composite captures the general concept of potentially avoidable hospitalization connecting the individual PQI measures, which are all rates at the area level. Separate composite measures were created for acute and chronic conditions to investigate different factors influencing hospitalization rates for each condition. The PQI composites are intended to be used to provide national estimates that can be tracked over time and to provide state and county level estimates that can be compared with the national estimate and to each other.

Process and Improvement Milestones

Milestone of this project will include:

DY2 – P-1 Project planning
DY3 – P- 2 Establish baseline rate
P- 3 Develop and test data systems
DY4 – IT-2.12 Decrease composite by 5% from baseline
DY5 - IT-2.12 Decrease composite by 5% from DY4

Data Source: EHR, Claims

Rationale

The project will capture the three overall composites outlined in the RHP 9 planning protocol: PQI 90 – overall composite, PQI 91 – acute composite, and PQI 92 – chronic composite. These composites will be calculated using the methodology and conditions outlined in the planning protocol.

Rationale/Evidence: An overall composite captures the general concept of potentially avoidable hospitalization connecting the individual PQI measures, which are all rates at the area level. Separate composite measures were created for acute and chronic conditions to investigate different factors influencing hospitalization rates for each condition. The PQI composites are intended to be used to provide national estimates that can be tracked over time and to provide state and county level estimates that can be compared with the national estimate and to each other.

Related Category 1 or 2 Projects

- 175287501.2.1—Implementation of an emergency department patient navigation system

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that connects patients to primary care providers if they do not have such a relationship when seen in the ED. This project will serve all patients seen but Medicaid patients frequently do not have adequate follow up with a primary care physician so they should benefit significantly. Currently, the ED at UT Southwestern University hospitals sees 33-35,000 visits per year. Of these patients, approximately 11% are unfunded or have Medicaid and 30% do not have an identified Primary Care Physician (PCP) using third quarter 2012 data. The target population will be the 9,900 – 10,500 patients seen in the Emergency Department without a primary care physician. We estimate that 1080 – 1150 of these patients will have Medicaid or be indigent based on the above numbers and percentages. The cost avoidance realized in this project will be measured by reduced preventable admissions. During the baseline determination, the project will determine the number of preventable admissions then reduce those admissions by 5% during DY4 and DY5 each. According to the RHP 9 Needs Assessment, each of the avoided admissions will save Medicaid patients $47,500.

Significant avoidable cost will be realized to the system if hospitalization can be avoided in these patients. The community benefit is obvious as primary care is facilitated and hospitalizations prevented.

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-

point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weigh– 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

This project's score for this criteria: 2 X 2 = 4

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

This project's score for this criteria: 1.8 X 2 = 3.6

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 1.75 X 2 = 3.5

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 2 X 2 = 4

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 2 X 2 = 4

Total Valuation Score for this project: 8.80

Unique Cat 3 ID: 175287501.3.2	*Reference Number: IT-2.12*	Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions *(Standalone measure)*	
The UT Southwestern University Hospitals			*TPI 175287501*
Related Category 1 or 2 Projects:	*175287501.2.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning Processes with documentation Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $146,196	**Process Milestone 2** [P-2]: Establish baseline composite Goal: Establish the baseline Data Source: EHR and claims data **Process Milestone 2 Payment:** $56,487 **Process Milestone 3 (P-3):** Develop and test data systems; Goal: Develop capability to collect, analyze and report clinical and administrative data to support project Data Source: EHR **Process Milestone 3 Payment:** $56.487 **Process Milestone 4 (P-4):** Conduct PDSA to improve data collection and intervention activities; Goal: Improve capability to collect, analyze and report clinical and administrative data to support project Data Source: EHR **Process Milestone 4 Payment:**	**Outcome Improvement Target 1** IT-2.12 Improvement Target: Decrease preventable admission composite by 5% from baseline Data Source: EHR and administrative data **Outcome Improvement Target 1 Payment*:*** $271,925	**Outcome Improvement Target 2** IT-2.12 Improvement Target: Decrease preventable admission composite by 5% from DY4 Data Source: HER an administrative data **Outcome Improvement Target 2 Payment*:*** $650,255

Unique Cat 3 ID: 175287501.3.2	*Reference Number: IT-2.12*	Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions *(Standalone measure)*	
The UT Southwestern University Hospitals			*TPI 175287501*
Related Category 1 or 2 Projects:	*175287501.2.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	$56,487		
Year 2 Estimated Outcome Amount: $146,196	**Year 3 Estimated Outcome Amount:** $169,461	**Year 4 Estimated Outcome Amount:** $271,925	**Year 5 Estimated Outcome Amount:** $650,255
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,237,837			

Title of Outcome Measure (Improvement Target): OD-13 Palliative Care

Unique RHP outcome identification number(s): 175287501.3.3

Performing Provider Name/TPI: The UT Southwestern University Hospital/ 175287501

Outcome Measure Description:

Timely pain assessment has been identified as a key determinant of quality of life and degree of satisfaction with care in patients needing palliative care services. For this reason we have chosen the following improvement outcome for this project.

IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure)
Increase the number of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.

Process Milestones:

DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:
Increase to 75% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
DY5:
Increase to 90% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.

Rationale:

Reasearch shows that the prevalence of pain among patients with incurable illness and at the end of life is high. In addition pain severity is underrecognized by clinicians and undertreated,

resulting in excess suffering among these patients. Pain screening and assessments will thus be a good measure of the quality of palliative care services provided to patients.

It is expected that this new service at the University Hospitals and Clinics will care for 900 inpatients consultations of which 100 will be Medicaid patients and account for 3000 outpatient visits over the span of the project of which 90 will be Medicaid patients in need of palliative care services.

Outcome Measure Valuation:

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

   This project's score for this criteria: 3 X 2 = 6

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

   This project's score for this criteria: 2.5 X 2 = 5

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

   This project's score for this criteria: 3.5 X 2 = 7

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 2.45 X 2 = 4.90

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 3 X 2 = 6

Total Valuation Score for this project: **5.49**

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed equally across the projects' related Category 3 measures.

Unique Cat 3: 175287501.3.3	*3.IT-13.1*	*Pain assessment (NQF-1637) (Non-standalone measure)*	
The University of Texas Southwestern University hospitals			175287501
Related Category 1 or 2 Projects:	**175287501.2.2**		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: [P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: document planning Data Source: administrative records **Process Milestone 1 Estimated Incentive Payment*:* $74,248**	**Process Milestone 2**: [P-2] Establish baseline rates Goal: establish baseline Data source: EHR and administrative records **Process Milestone 2 Estimated Incentive Payment: $43,032** **Process Milestone 3:** [P-3] Develop and test data systems Data source: EHR and registry **Process Milestone 3 Estimated Incentive Payment: $43,032**	**Outcome Improvement Target 1:** [IT-13.1] Increase to 75% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter. Data Source: EHR **Outcome Improvement Target 1 Estimated Incentive Payment*:* $138,103**	**Outcome Improvement Target 2:** [IT-13.1] Increase to 90% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter. Data Source: EHR **Outcome Improvement Target 2 Estimated Incentive Payment*:* $330,245**
Year 2 Estimated Outcome Amount: $74,248	Year 3 Estimated Outcome Amount: $86,064	Year 4 Estimated Outcome Amount: $138,103	Year 5 Estimated Outcome Amount: $330,245
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $628,660			

Title of Outcome Measure (Improvement Target): OD-13 Palliative Care

Unique RHP outcome identification number(s): 175287501.3.4

Performing Provider Name/TPI: The University of Texas Southwestern University Hospital/ 175287501

Outcome Measure Description:

Helping patients in need of end of life care with documentation of life sustaining preferences and enrollment in appropriate hospice care is important to maintain quality of care for patients with life threatening disease. For this reason, we have chosen the followin as one of the improvement measurements for this project.

IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure)
Percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments.

Process Milestones:

DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
Increase to 75% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments.
DY5:
Increase to 90% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments.

Rationale:
In the absence of a clear guideline for end-of-life care, care decisions are often taken by the physician/care team and this tends to be in favor of life sustaining treatments. As a result of these aggressive treatments, many expensive interventions are given to patients in the last few months of life with poor and questionable outcomes. Site of death accounts for significant

variation in end-of-life costs. Medicare beneficiaries who die in a hospital inpatient setting have been found to be twice those for beneficiaries who died in other settings such as their homes . Palliative care services address these imbalances and this measure assesses the success of the project by assessing how much patient preferences are being respected.

It is expected that this new service at the University Hospitals and Clinics will care for 900 inpatients consultations of which 100 will be Medicaid patients and account for 3000 outpatient visits over the span of the project of which 90 will be Medicaid patients in need of palliative care services.

Outcome Measure Valuation:

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

   This project's score for this criteria: 3 X 2 = 6

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

   This project's score for this criteria: 2.5 X 2 = 5

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 3.5 X 2 = 7

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 2.45 X 2 = 4.90

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 3 X 2 = 6

Total Valuation Score for this project: **5.49**

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed equally across the projects' related Category 3 measures.

Unique Cat 3: 175287501.3.4	*3.IT-13.2*	*Treatment Preferences (NQF 1641) (Non-standalone measure)*	
The University of Texas Southwestern University hospitals			**175287501**
Related Category 1 or 2 Projects:	**175287501.2.2**		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: [P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal:Plan completed Data Source: administrative records **Process Milestone 1 Estimated Incentive Payment*:* $74,249**	**Process Milestone 2:** [P-2] Establish baseline rates Goal; baseline established Data source: EHR **Process Milestone 2 Estimated Incentive Payment: $43,032** **Process Milestone 3:** [P-3] Develop and test data systems Data source: EHR and registry **Process Milestone 3 Estimated Incentive Payment: $43,032**	**Outcome Improvement Target 1:** [IT-13.2] Increase to 75% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $138,103	**Outcome Improvement Target 2:** [IT-13.2] Increase to 90% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments. Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $330,245
Year 2 Estimated Outcome Amount: $74,249	Year 3 Estimated Outcome Amount: $86,064	Year 4 Estimated Outcome Amount: $138,103	Year 5 Estimated Outcome Amount: $330,245
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $628,660			

Title of Outcome Measure (Improvement Target): OD-13 Palliative Care

Unique RHP outcome identification number(s): 175287501.3.5

Performing Provider Name/TPI: The University of Texas Southwestern University Hospital/ 175287501

Outcome Measure Description:

Spiritual and religious concerns regarding the process of dying are a frequently overlooked need in patients receiving palliative care. For this reason we have chosen the following improvement measure for this project.

IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)

Increase the number of patients discharged from hospice or palliative care with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period.

Process Milestones:

DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:
Increase to 75% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period.
DY5:
Increase to 90% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period.

Rationale:

A comprehensive interdisciplinary approach is one of the hallmarks of pallaitive care, and this entails caring for the physical, psychosocial, and spiritual needs of patients and their families. An essential step to providing for the needs of patients is initiating discussions about their spiritual concerns. This measure will thus be an important indicator of the quality of palliative care provided throught this project.
It is expected that this new service at the University Hospitals and Clinics will care for 900 inpatients consultations of which 100 will be Medicaid patients and account for 3000 outpatient visits over the span of the project of which 90 will be Medicaid patients in need of palliative care services.

Outcome Measure Valuation:

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

   This project's score for this criteria: 3 X 2 = 6

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

   This project's score for this criteria: 2.5 X 2 = 5

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 3.5 X 2 = 7

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 2.45 X 2 = 4.90

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 3 X 2 = 6

Total Valuation Score for this project: **5.49**

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed equally across the projects' related Category 3 measures.

Unique Cat 3: 175287501.3.5	IT-13.5	*Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-st*	
The University of Texas Southwestern University Hospitals			175287501
Related Category 1 or 2 Projects:	**175287501.2.2**		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: [P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: completed plan Data Source: administrative records **Process Milestone 1 Estimated Incentive Payment*:* $74,249**	**Process Milestone 2:** [P-2] Establish baseline rates **Process Milestone 2 Estimated Incentive Payment: $43,032** **Process Milestone 3:** [P-3] Develop and test data systems Data source: EHR and registry **Process Milestone 3 Estimated Incentive Payment: $43,032**	**Outcome Improvement Target 1:** [IT-13.5] Increase to 75% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period. Data source: EHR **Outcome Improvement Target 1 Estimated Incentive Payment*:* $138,103**	**Outcome Improvement Target 2:** [IT-13.5] Increase to 90% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period. Data source: EHR **Outcome Improvement Target 2 Estimated Incentive Payment*:* $330,245**
Year 2 Estimated Outcome Amount: $74,249	Year 3 Estimated Outcome Amount: $86,064	Year 4 Estimated Outcome Amount: $138,103	Year 5 Estimated Outcome Amount: $330,245
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $628,660			

Title of Outcome Measure (Improvement Target): IT-3.12 Other - readmission rate (Cancer) *(Standalone measure)*

Unique RHP outcome identification number: 175287501.3.6

Performing provider name/TPI: The University of Texas Southwestern University Hospitals/ TPI 175287501

Outcome Measure Description

IT-3.12 Other - readmission rate [*To be selected by provider*] *(Standalone measure).* The provider chooses cancer admissions for this readmission project.

Numerator: The number of readmissions (for patients 18 years and older), for any cause, from the index admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of Cancer and with a complete claims history for the 12 months prior to admission.

Process and Improvement Milestones

Milestone of this project will include:

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
P- 3 Develop and test data systems
DY4 - IT- 3.12 Decrease the readmission rate for patients with cancer by X% (TBD) from baseline
DY5 - IT- 3.12 Decrease the readmission rate for patients with cancer by X% (TBD) from DY4

Data Source: EHR, Claims

Rationale

The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. Cancer patients in particular have high hospital readmission rates and high rates are considered by some as an indication of weakness in the

overall care of patients with a particular condition. Only readmissions to the same facility will be included as part of each hospital's rates.

Outcome Measure Valuation

The valuation of the milestones includes costs and potential benefits of developing a system that uses a registry to identify patients, analyze clinical and administrative and address the medical needs of those patients identified as having a high risk of developing complications of cancer and its treatment. The populations served will be oncology patients of UT Southwestern faculty practice and the affiliated primary care network described in a previous project. The community benefit is obvious as complications from cancer treatment are common and the costs of hospitalization for these complications can be avoided.

Related Category 1 or 2 Projects

175287501.2.3 Transitional Care for Cancer Patients
126686802.1.11 Oncology Urgent Care Services
175287501.2.2 Palliative Care

Unique Cat 3 ID: 175287501.3.6	*Reference Number: IT-3.12*	Other - readmission rate (Cancer) *(Standalone measure)*	
The University of Texas Southwestern University Hospitals			*TPI 175287501*
Related Category 1 or 2 Projects:	*175287501.2.3*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Engage stakeholders, determine timeline and implementation plans. Goal: Complete planning processes Data Source: Documentation of planning reports **Process Milestone 1 Payment*:*** $211,111	**Process Milestone 2** [P-2]: Establish baseline cancer readmission rates Goal: Establish the baseline for patients aged 18 and over Data Source: EHR and claims data **Process Milestone 2 Payment:** $122,353 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Improve data collection, reporting and analytic functions as well as intervention strategies Data Source: EHR and administrative records **Process Milestone 3 Payment:** $122,353	**Outcome Improvement Target 1** [IT-3.12]: Improvement Target: **Outcome** Decrease readmission rate for cancer patient by X% (TBD) from baseline Data Source: EHR and administrative records **Outcome Improvement Target 1 Payment*:*** $392,667	**Outcome Improvement Target 2** [IT-3.12]: Improvement Target**: Outcome** Decrease readmission rate for cancer patient by X% (TBD) from DY4 Data Source: EHR and administrative records **Outcome Improvement Target 2 Payment*:*** $938,987
Year 2 Estimated Outcome Amount: $211,111	**Year 3 Estimated Outcome Amount:** $244,706	**Year 4 Estimated Outcome Amount:** $392,667	**Year 5 Estimated Outcome Amount:** $938,987
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,787,471			

Title of Outcome Measures (Improvement Target): IT-4.2 Central line-associated bloodstream infections (CLABSI) rates *(Standalone measure)*

Unique RHP outcomes identification number: 175287501.3.7

Performing provider: The University of Texas Southwestern University Hospitals/ 175287501

Outcome Measure Description

Transplant patients are immunosuppressed by rejection preventing medications so are more likely to suffer from infectious complications of treatment. One of the complications is blood stream infections secondary to central line catheters. Many of these infections are considered preventable. Decreasing the number of these infections has been identified by AHRQ as a high priority .

Numerator: Number of cases of CLABSI as designated by IQR criteria251

Data Source: EHR, Claims, IQR/NHSN data

Process and Improvement Milestones

The milestones for this project will be as follows:

DY2 – P-2 establish baseline rates of central line infections in transplanted patients
P-3 Develop and test data systems
DY3 – P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
DY4 – Decrease the number of central line related blood stream infections in target transplant patients by 10 percent from baseline
DY5 – Decrease the number of central line related blood stream infections in target transplant patients by 10 percent from DY4

Rationale

Rationale/Evidence: An estimated 41,000 central line-associated bloodstream infections (CLABSI) occur in U.S. hospitals each year. These infections are usually serious infections typically causing a prolongation of hospital stay and increased cost and risk of mortality. CLABSI can be prevented through proper management of the central line. These techniques are addressed in the CDC's Healthcare Infection Control Practices Advisory Committee (CDC/HIPAC) Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011. This complications is particularly severe in immunosuppressed partients.

Outcome Measure Valuation:

The valuation of this project is based on the potential benefit these patients will receive from the needed transplant and the cost of providing the evaluation, transplant itself and related post-transplant care. Prevention of a single central line infection has been estimate to save $40,000 in avoidable costs.

The valuation of this project takes into account two factors. First, the number of patients that need to be evaluated to result in one transplant was considered. The cost of this evaluation is significant and must be borne by the performing provider when outside funding does not exist. The cost of the transplant and recovery with follow up care was also considered. In addition, the number of patients who need bridging with a VAD (ventricular assistance device) was considered for the heart transplant patients. Finally, the possible avoidable cost of recurrent hospitalizations for chronic conditions precipitating the consideration for transplant for the patients, especially if the program is later scaled to a larger population, was an important factor if community and future medical costs are considered. Patients with severe chronic liver disease, congestive heart failure and chronic lung disease who would be considered for transplant utilize inpatient services in the form of recurrent hospitalizations to stabilize their chronic condition. Transplantation offers the advantage over medical treatment of these patients of decreasing the need for recurrent hospitalization and improving overall quality of life (Jarl and Gerdtham, 2011).

The anchor, Parkland Health System, established six (6) criteria, to be rated based on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) per project. The total score per project was divided by the percent of total DSRIP funds available for that year, arriving at a dollar value multiplier to be applied towards each project's total score (value weight). This method apportioned available funds towards those projects valued highest. UT Southwestern used this approach, with the following exceptions. First, we selected the following criteria as being most significant to differentiate between projects: (i) Transformational Impact, (ii) Population Serviced/Project Size, (iii) Aligned with Community Needs, (iv) Cost Avoidance, and (v) Sustainability. Second, we began with a 5-point scale for each criteria rated, and then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

   This project's score for this criteria: 4.5 X 2 = 9

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected. Score - Four points for the whole population, 3 points for a

relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population.

This project's score for this criteria: 4.5 X 2 = 9

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 4.5 X 2 = 9

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 5 X 2 = 10

5. Sustainability (Weight = 15%): Points were awarded based on judgment of project's sustainability relative to other projects. Score – 5 points for very sustainable, 4 points for high sustainability, 3 points for moderate sustainability, 2 points for somewhat sustainable, 1 point for low sustainability.

This project's score for this criteria: 4.84 X 2 = 9.67

Total Valuation Score for this project: 8.80

These values are provided for in the table below and are allocated equally amongst the milestones

Related Category 1 or 2 Projects

175287501.1.1—Expanding specialty care capacity by providing access to bone marrow and solid organ transplants for patients with inadequate funding.

Unique Cat 3 ID: 175287501.3.7	*Reference Number: IT-4.2*	Central line-associated bloodstream infections (CLABSI) rates *(Standalone measure)*	
The University of Texas Southwestern University Hospitals			*TPI 175287501*
Related Category 1 or 2 Projects:	*175287501.1.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Establish baseline rates of central line associated blood stream infections in transplant patients Metric: number of central line infections as identified by IRQ criteria 251 Improvement target: 100% accuracy in identifying central line infections by established definition Data Source: EHR, Infection Prevention data (NSHN) and billing data **Process Milestone 1 Estimated Incentive Payment***:* $89,347 **Process Milestone 2** [P-3]: Develop and test data systems Metric: accuracy of data systems in capturing central line infections Data Source: EHR, Infection prevention data base, billing data Improvement target: 100% accuracy in capturing all central line infections in transplanted patients Process Milestone 2 Estimated	**Process Milestone 3 (P-4**) Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Improvement target: Sufficient number of cycles to maximize data collection and intervention activities Data Source: Quality improvement Office administrative records, EHR and administrative records of center **Process Milestone 3 Estimated Incentive Payment**: $207,130	**Outcome Improvement Target 1** Reduce baseline rate of central line infections by 10% from baseline Metric: rate of central line infections Data Source: EHR and transplant center records **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $332,372	**Outcome Improvement Target 2** Reduce baseline rate of central line infections by 10% from DY4 Metric: rate of central line infections Data Source: EHR and transplant center records **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $794,802

Unique Cat 3 ID: 175287501.3.7	*Reference Number: IT-4.2*	Central line-associated bloodstream infections (CLABSI) rates *(Standalone measure)*	
The University of Texas Southwestern University Hospitals			*TPI 175287501*
Related Category 1 or 2 Projects:	*175287501.1.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Incentive Payment*:* $89,347			
Year 2 Estimated Outcome Amount: $178,695	Year 3 Estimated Outcome Amount: $207,130	Year 4 Estimated Outcome Amount: $332,372	Year 5 Estimated Outcome Amount: $794,802
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,512,997			

F. Category 4: Population-Focused Improvements (Hospitals Only)

Performing Provider Name: Baylor Medical Center at Carrollton

Texas Provider Identifier: 195018001

Baylor Medical Center at Carrollton will be reporting all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Baylor Medical Center at Carrollton healthcare reporting system indicates further refinement and definition will be required for some of the required metrics. The reporting system has the capability to track and report the required measurements but will require additional work to get the exact required specifications. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Domain #1 – Potentially Preventable Admissions (8 measures)
Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, 8 of the eight measurements are being tracked and reported at Baylor Medical Center at Carrollton. In addition, many regional DSRIP projects will provide interventions to Baylor Medical Center at Carrollton patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor Medical Center at Carrollton will expand the existing data collecting system, and optimize the old system for new reporting processes.
The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor Medical Center at Carrollton has chosen will be 10/1 to 3/31.

b. Describe how Category 4 measures relate to project(s)/outcomes(s) in Categories 1, 2, and 3.

The PPA domain in Category 4 has 8 components. Although the impact of the Baylor Medical Center at Carrollton's DSRIP projects on the PPA domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPA domain. The projects and outcomes listed below will help to reduce/prevent

PPAs in patients who engage in these programs, are actively managed and have their conditions under control.
The table below summarizes the projects and outcomes that potentially relate to the PPA domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD1- PPA						
Cat 1, 2, & 3	1.1	1.2	1.3	1.4	1.5	1.7	1.8
195018001.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X	X		X	X	X	X
IT 1.7 Controlling high blood pressure					X		
IT 12.5 Influenza Vaccination rate							X
195018001.2.1: Expand Chronic Care Management Model- Create Chronic Disease management and Prevention Program	X	X		X	X		
IT 1.10 Diabetes HbA1c poor control		X					
IT 1.11 Diabetes BP control		X					
IT 1.13 Diabetes Foot exam		X					
195018001.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect	X	X	X	X	X		
195018001.2.2 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment	X	X	X	X		X	X
IT 11.1 Diabetes Management for underserved with BH diagnoses		X					
IT 11.3 improve utilization rate of clinical preventive services f or BH			X				

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPAs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPAs.

Domain Valuation: Supporting information may be included in the addendums.

a. **Approach/Methodology:** Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. **Rationale/Justification:** Please describe your rationale for valuing this domain .
All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor Medical Center at Carrollton, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #2 – 30 Day Readmissions (7 measures)
Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.
Currently, 7 of the seven measurements are being tracked and reported at Baylor Medical Center at Carrollton. In addition, many regional DSRIP projects will provide interventions to Baylor Medical Center at Carrollton patients in multiple areas, resulting in improvement of PPRs throughout all measurements in the Reporting Domain. One note is that PPRs are reported within Baylor Health Care System only. Thus, if a patient presents at a Baylor facility and then is readmitted at another provider's facility, we cannot capture that data.

Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor Medical Center at Carrollton will expand the existing data collecting system, and optimize the old system for new reporting processes.
The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor Medical Center at Carrollton has chosen will be 10/1 to 3/31.

b. Describe how Category 4 measures relate to projects/outcomes(s) in Categories 1, 2, and 3.
The PPR domain in Category 4 has 7 components. Although the impact of the Baylor Medical Center at Carrollton's DSRIP projects on the PPR domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPR domain. The projects and outcomes listed below will help to reduce/prevent PPRs in patients who engage in these programs, are actively managed and have their conditions under control.
The table below summarizes the projects and outcomes that potentially relate to the PPR domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD2- PPR					
Cat 1, 2, & 3	2.1	2.2	2.3	2.4	2.5	2.7
195018001.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X	X	X	X	X	X
IT 1.7 Controlling high blood pressure					X	
195018001.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X	X		X	X	
IT 1.10 Diabetes HbA1c poor control		X				
IT 1.11 Diabetes BP control		X				
IT 1.13 Diabetes Foot exam		X				
195018001.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect	X	X	X	X	X	X
195018001.2.2 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment			X			
IT 11.1 Diabetes Management for underserved with BH diagnoses		X				
IT 11.3 improve utilization rate of clinical preventive services for BH			X			

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPRs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPRs.

Domain Valuation: Supporting information may be included in the addendums.

a. Approach/Methodology: Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. Rationale/Justification: Please describe your rationale for valuing this domain .

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor Medical Center at Carrollton, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #3 – Potentially Preventable Complications, PPC (1 measure, but 64 reportable metrics)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, many of the sixty four measurements are being tracked and reported at Baylor Medical Center at Carrollton. In addition, many regional DSRIP projects will provide interventions to Baylor Medical Center at Carrollton patients in multiple areas, resulting in improvement of PPCs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor Medical Center at Carrollton will expand the existing data collecting system, and optimize the old system for new reporting processes.

The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor Medical Center at Carrollton has chosen will be 10/1 to 3/31.

b. Describe how Category 4 measures relate to projects/outcomes(s) in Categories 1, 2, and 3.

The PPC domain in Category 4 has 1 component with 64 reportable measures. Although the impact of the Baylor Medical Center at Carrollton's DSRIP projects on the PPC domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPC domain. The projects and outcomes listed below will help to reduce/prevent PPCs in patients who engage in these programs, are actively managed and have their conditions under control. We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPCs should improve. Getting patients into a PCMH, managing their chronic diseases, and specialty care needs will help to reduce PPCs in the inpatient setting. For example, helping a patient control their diabetes in the outpatient setting may help to reduce PPC # 26: Diabetic Ketoacidosis and Coma or PPC #38 Post-Operative Infection and Deep Wound Disruption with Procedure (if a patient has well controlled diabetes, they may be less susceptible to post-operative infections).The correlation between outpatient management and PPCs is weak and the overall impact of outpatient interventions on PPCs may be minimal.

The table below summarizes the projects and outcomes that potentially relate to the PPC domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD3- PPCs
Cat 1, 2, & 3	

195018001.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X
IT 1.7 Controlling high blood pressure	X
195018001.1.2 :Improve Access to Specialty Care- Expand Specialty care Services	X
IT 12.2 Cervical Cancer Screening	X
IT 12.3 Colorectal Cancer Screening	X
195018001.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X
IT 1.10 Diabetes HbA1c poor control	X
IT 1.11 Diabetes BP control	X
IT 1.13 Diabetes Foot exam	X
195018001.2.2 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment	X
IT 11.1 Diabetes Management for underserved with BH diagnoses	X
IT 11.3 improve utilization rate of clinical preventive services for BH	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.
We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPCs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPCs in the inpatient setting.

Domain Valuation: Supporting information may be included in the addendums.

a. Approach/Methodology: Please describe your approach for valuing this domain.
All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. Rationale/Justification: Please describe your rationale for valuing this domain
All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor Medical Center at Carrollton, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #4 – Patient-Centered Healthcare (2 measures)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, 2 of the two measurements are being tracked and reported internally within the Baylor Healthcare System's Office of Patient Centeredness and Quality Reporting and Analytics departments. Although Baylor Medical Center at Carrollton does not have any projects directly related to patient satisfaction in the inpatient realm, one of our care navigation projects will most likely positively impact inpatient patient satisfaction. Baylor Medical Center at Carrollton will expand existing data collecting systems, and optimize the old system for new reporting processes.

b. Describe how Category 4 measures relate to project(s)/outcomes(s) in Categories 1, 2, and 3.

Baylor Medical Center at Carrollton does not have any projects that directly address patient satisfaction measures in the inpatient setting. We do have projects in the ambulatory realm which will measure the impact of patient satisfaction. We do believe that the Care Connect project mentioned in the table below will help improve patient satisfaction scores in the inpatient setting through providing care coordination and continuity of care services.

Category 4	RD4- IP Pat Sat	
Cat 1, 2, & 3	4.1	4.2
195018001.2.3: Establish/Expand a Patient Care Navigation Program-Care Connect	X	X
IT 9.2 ED appropriate utilization	X	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect to see improvements in patient satisfaction for those patients who have engaged in the Care Connect program. Historically, we have not measured this impact of the program and thus do not have any data on the direct impact on patient satisfaction.

Domain Valuation: Supporting information may be included in the addendums.

a. **Approach/Methodology:** Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. **Rationale/Justification:** Please describe your rationale for valuing this domain including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor Medical Center at Carrollton, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #5 – Emergency Department (1 measure)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Baylor Medical Center at Carrollton has the data infrastructure and processes to track admit decision time to discharge. Some modification may be required to satisfy the requirement of new reporting domain.

b. Describe how Category 4 measures relate to project(s)/outcomes(s) in Categories 1, 2, and 3.

This domain only has 1 component which measures the time between admit decision to discharge in the ED. The majority of our projects are not physically located in the hospital other than our Care Connect program. We anticipate that if a patient is identified as a candidate for Care Connect in the ED, they can be triaged to community based or non-hospital based resource more quickly, leading to a shorter admit to discharge time duration.

Category 4	RD5- ED
195018001.2.3: Establish/Expand a Patient Care Navigation Program-Care Connect	X
IT 5.1 Improve cost savings	
IT 9.2 ED appropriate utilization	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that as the Care Connect program develops and expands that the time patients spend in the ED will decrease. Care Connect entails a comprehensive care coordination and case management system which can help to move patients to appropriate care settings more quickly.

Domain Valuation: Supporting information may be included in the addendums.

a. **Approach/Methodology:** Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. **Rationale/Justification:** Please describe your rationale for valuing this domain including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor Medical Center at Carrollton, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Option Domain #6 – Initial Core Set of Health Care Quality Measures (minimum of 12 measures listed in HHSC guidance. If additional measures are proposed, please describe in the narrative and list them in the table below). Optional, but required if requesting maximum Category Valuation of 15%.

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

b. Describe how Category 4 measures relate to project(s)/outcomes(s) in Categories 1, 2, and 3.

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

Domain Valuation: Supporting information may be included in the addendums.

a. **Approach/Methodology:** Please describe your approach for valuing this domain.

b. Rationale/Justification: Please describe your rationale for valuing this domain including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc.

Category 4: Population-Focused Measures *[Baylor Medical Center at Carrollton/195018001]*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$ 26,830	$ 0		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Domain 1 - Estimated Maximum Incentive Amount		$ 15,550	$ 13,309	$ 14,465
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1: 10/1/ 2015-3/31/2016	1:10/1/ 2016-3/31/ 2017	1: 10/1/ 2015-3/31/2016
Domain 2 - Estimated Maximum Incentive Amount		$ 15,550	$ 13,309	$ 14,465
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1: 10/1/ 2015-3/31/2016	1:10/1/ 2016-3/31/ 2017
Domain 3 - Estimated Maximum Incentive Amount			$ 13,309	$ 14,465
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Medication Management				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Domain 4 - Estimated Maximum Incentive		$ 15,551	$ 13,309	$ 14,465

Amount				
Domain 5: Emergency Department				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Domain 5 - Estimated Maximum Incentive Amount		$ 15,551	$ 13,308	$ 14,465
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$ 26,830	$ 62,202	$66,544	$ 72,325

Performing Provider Name: Baylor Medical Center at Garland

Texas Provider Identifier: 121790303

Baylor Medical Center at Garland will be reporting all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Baylor Medical Center at Garland healthcare reporting system indicates further refinement and definition will be required for some of the required metrics. The reporting system has the capability to track and report the required measurements but will require additional work to get the exact required specifications. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Domain #1 – Potentially Preventable Admissions (8 measures)
Domain Description:

d. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, 8 of the eight measurements are being tracked and reported at Baylor Medical Center at Garland. In addition, many regional DSRIP projects will provide interventions to Baylor Medical Center at Garland patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor Medical Center at Garland will expand the existing data collecting system, and optimize the old system for new reporting processes. The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor Medical Center at Garland has chosen will be 10/1 to 3/31.

e. Describe how Category 4 measures relate to project(s)/outcomes(s) in Categories 1, 2, and 3.

The PPA domain in Category 4 has 8 components. Although the impact of the Baylor Medical Center at Garland's DSRIP projects on the PPA domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPA domain. The projects and outcomes listed below will help to reduce/prevent PPAs in patients who engage in these programs, are actively managed and have their conditions under control. The table below summarizes the projects and outcomes that potentially relate to the PPA domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD1- PPA							
Cat 1, 2, & 3	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
121790303.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X	X		X	X	N/A	X	X
IT 1.7 Controlling high blood pressure					X	N/A		
IT 12.5 Influenza Vaccination rate						N/A		X
121790303.1.2 :Improve Access to Specialty Care- Expand Specialty care Services				X		N/A		
IT 11.1 Asthma management for underserved				X		N/A		
121790303.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X	X		X	X	N/A		
IT 1.10 Diabetes HbA1c poor control		X				N/A		
IT 1.11 Diabetes BP control		X				N/A		
IT 1.13 Diabetes Foot exam		X				N/A		
121790303.2.2: Establish/Expand a Patient Care Navigation Program- Care Connect	X	X	X	X	X	N/A		
121790303.2.3 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment	X	X	X	X		N/A	X	X
IT 11.1 Diabetes Management for underserved with BH diagnoses		X				N/A		
IT 11.3 improve utilization rate of clinical preventive services for BH			X			N/A		
121790303.2.4 : 2.12.2 – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)	X	X	X	X	X	N/A	X	X
IT-10.1: Quality of Life.	X	X	X	X	X	N/A	X	X
IT-10.2: Activities of Daily Living	X	X	X	X	X	N/A	X	X
121790303.2.5 : 2.11.3 – Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program	X	X	X	X	X	N/A	X	X
IT-1.2 Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs	X		X		X	N/A		
IT-1.4 Annual monitoring for patients on persistent medications– diuretic	X		X		X	N/A		
IT-1.5 Annual monitoring for patients on persistent medications- anticonvulsant			X			N/A		
IT-1.19 Antidepressant Medication Management	X	X	X	X	X	N/A	X	X

f. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPAs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPAs.

Domain Valuation: Supporting information may be included in the addendums.

c. **Approach/Methodology:** Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

d. **Rationale/Justification:** Please describe your rationale for valuing this domain .

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At , the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #2 – 30 Day Readmissions (7 measures)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, 7 of the seven measurements are being tracked and reported at Baylor Medical Center at Garland. In addition, many regional DSRIP projects will provide interventions to Baylor Medical Center at Garland patients in multiple areas, resulting in improvement of PPRs throughout all measurements in the Reporting Domain. One note is that PPRs are reported within Baylor Health Care System only. Thus, if a patient presents at a Baylor facility and then is readmitted at another provider's facility, we cannot capture that data.

Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor Medical Center at Garland will expand the existing data collecting system, and optimize the old system for new reporting processes.

The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor Medical Center at Garland has chosen will be 10/1 to 3/31.

b. Describe how Category 4 measures relate to project(s)/outcomes(s) in Categories 1, 2, and 3.

The PPR domain in Category 4 has 7 components. Although the impact of the Baylor Medical Center at Garland's DSRIP projects on the PPR domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPR domain. The projects and outcomes listed below will help to reduce/prevent PPRs in patients who engage in these programs, are actively managed and have their conditions under control. The table below summarizes the projects and outcomes that potentially relate to the PPR domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD2- PPR						
Cat 1, 2, & 3	2.1	2.2	2.3	2.4	2.5	2.6	2.7
121790303.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X	X	X	X	X	N/A	X
IT 1.7 Controlling high blood pressure					X	N/A	
121790303.1.2 :Improve Access to Specialty Care- Expand Specialty care Services				X		N/A	
IT 11.1 Asthma management for underserved				X		N/A	
121790303.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X	X		X	X	N/A	
IT 1.10 Diabetes HbA1c poor control		X				N/A	
IT 1.11 Diabetes BP control		X				N/A	
IT 1.13 Diabetes Foot exam		X				N/A	
121790303.2.2: Establish/Expand a Patient Care Navigation Program- Care Connect	X	X	X	X	X	N/A	X
121790303.2.3 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment			X			N/A	
IT 11.1 Diabetes Management for underserved with BH diagnoses		X				N/A	
IT 11.3 improve utilization rate of clinical preventive services for BH			X			N/A	
121790303.2.4 : 2.12.2 – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)	X	X	X	X	X	N/A	X
IT-10.1: Quality of Life.	X	X	X	X	X	N/A	X
IT-10.2: Activities of Daily Living	X	X	X	X	X	N/A	X

121790303.2.5 : 2.11.3 – Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program	X	X	X	X	X	N/A	X
IT-1.2 Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs	X		X		X	N/A	X
IT-1.4 Annual monitoring for patients on persistent medications– diuretic	X		X		X	N/A	X
IT-1.5 Annual monitoring for patients on persistent medications- anticonvulsant			X			N/A	X
IT-1.19 Antidepressant Medication Management	X	X	X	X	X	N/A	X

a. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPRs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPRs.

Domain Valuation: Supporting information may be included in the addendums.

a. Approach/Methodology: Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. Rationale/Justification: Please describe your rationale for valuing this domain .

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor Medical Center at Garland, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #3 – Potentially Preventable Complications, PPC (1 measure, but 64 reportable metrics)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, many of the sixty four measurements are being tracked and reported at Baylor Medical Center at Garland. In addition, many regional DSRIP projects will provide interventions to Baylor Medical Center at Garland patients in multiple areas, resulting in improvement of PPCs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor Medical Center at Garland will expand the existing data collecting system, and optimize the old system for new reporting processes.
The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor Medical Center at Garland has chosen will be 10/1 to 3/31.

b. Describe how Category 4 measures relate to project/outcomes(s) in Categories 1, 2, and 3.
The PPC domain in Category 4 has 1 component with 64 reportable measures. Although the impact of the Baylor Medical Center at Garland's DSRIP projects on the PPC domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPC domain. The projects and outcomes listed below will help to reduce/prevent PPCs in patients who engage in these programs, are actively managed and have their conditions under control. We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPCs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPCs in the inpatient setting. For example, helping a patient control their diabetes in the outpatient setting may help to reduce PPC # 26: Diabetic Ketoacidosis and Coma or PPC #38 Post-Operative Infection and Deep Wound Disruption with Procedure (if a patient has well controlled diabetes, they may be less susceptible to post-operative infections).The correlation between outpatient management and PPCs is weak and the overall impact of outpatient interventions on PPCs may be minimal.

The table below summarizes the projects and outcomes that potentially relate to the PPC domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD3- PPCs
Cat 1, 2, & 3	
121790303.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X
IT 1.7 Controlling high blood pressure	X
121790303.1.2 :Improve Access to Specialty Care- Expand Specialty care Services	X
IT 11.1 Asthma management for underserved	X
IT 12.2 Cervical Cancer Screening	X
IT 12.3 Colorectal Cancer Screening	X

121790303.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X
IT 1.10 Diabetes HbA1c poor control	X
IT 1.11 Diabetes BP control	X
IT 1.13 Diabetes Foot exam	X
121790303.2.3 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment	X
IT 11.1 Diabetes Management for underserved with BH diagnoses	X
IT 11.3 improve utilization rate of clinical preventive services for BH	X
121790303.2.4 : 2.12.2 – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)	X
IT-10.1: Quality of Life.	X
IT-10.2: Activities of Daily Living	X
121790303.2.5 : 2.11.3 – Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program	X
IT-1.2 Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs	X
IT-1.4 Annual monitoring for patients on persistent medications– diuretic	X
IT-1.5 Annual monitoring for patients on persistent medications-anticonvulsant	X
IT-1.19 Antidepressant Medication Management	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exemptand state the reason.

We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPCs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPCs in the inpatient setting.

Domain Valuation: Supporting information may be included in the addendums.

a. Approach/Methodology: Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined

that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. Rationale/Justification: Please describe your rationale for valuing this domain

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor Medical Center at Garland, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #4 – Patient-Centered Healthcare (2 measures)

Domain Description:

d. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, 2 of the two measurements are being tracked and reported internally within the Baylor Healthcare System's Office of Patient Centeredness and Quality Reporting and Analytics departments. Although Baylor Medical Center at Garland does not have any projects directly related to patient satisfaction in the inpatient realm, one of our care navigation projects will most likely positively impact inpatient patient satisfaction. Baylor Medical Center at Garland will expand existing data collecting systems, and optimize the old system for new reporting processes.

e. Describe how Category 4 measures relate to project/outcomes in Categories 1, 2, and 3.

Baylor Medical Center at Garland does not have any projects that directly address patient satisfaction measures in the inpatient setting. We do have projects in the ambulatory realm which will measure the impact of patient satisfaction. Additionally, we do have a project that focuses on medication management (121790303.2.5); however this project occurs in an outpatient setting and would not impact inpatient measures We do believe that the Care Connect project mentioned in the table below will help improve patient satisfaction scores in the inpatient setting through providing care coordination and continuity of care services.

Category 4	RD4- IP Pat Sat	
Cat 1, 2, & 3	4.1	4.2
121790303.2.3: Establish/Expand a Patient Care Navigation Program-Care Connect	X	X
IT 9.2 ED appropriate utilization	X	X

f. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect to see improvements in patient satisfaction for those patients who have engaged in the Care Connect program. Historically, we have not measured this impact of the program and thus do not have any data on the direct impact on patient satisfaction.

Domain Valuation: Supporting information may be included in the addendums.

a. Approach/Methodology: Please describe your approach for valuing this domain.
All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. Rationale/Justification: Please describe your rationale for valuing this domain including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc
All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor Medical Center at Garland, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #5 – Emergency Department (1 measure)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.
Baylor Medical Center at Garland has the data infrastructure and processes to track admit decision time to discharge. Some modification may be required to satisfy the requirement of new reporting domain.

b. Describe how Category 4 measures relate to projects/outcomes(s) in Categories 1, 2, and 3.
This domain only has 1 component which measures the time between admit decision to discharge in the ED. The majority of our projects are not physically located in the hospital other than our Care Connect program. We anticipate that if a patient is identified as a candidate for Care Connect in the ED, they can be triaged to community based or non-hospital based resource more quickly, leading to a shorter admit to discharge time duration.

Category 4	RD5- ED

121790303.2.3: Establish/Expand a Patient Care Navigation Program-Care Connect	X
IT 5.1 Improve cost savings	
IT 9.2 ED appropriate utilization	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that as the Care Connect program develops and expands that the time patients spend in the ED will decrease. Care Connect entails a comprehensive care coordination and case management system which can help to move patients to appropriate care settings more quickly.

Domain Valuation: Supporting information may be included in the addendums.

a. **Approach/Methodology:** Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. **Rationale/Justification:** Please describe your rationale for valuing this domain including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor Medical Center at Garland, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Option Domain #6 – Initial Core Set of Health Care Quality Measures (minimum of 12 measures listed in HHSC guidance. If additional measures are proposed, please describe in the narrative and list them in the table below). Optional, but required if requesting maximum Category Valuation of 15%.

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

b. Describe how Category 4 measures relate to project(s)/outcomes(s) in Categories 1, 2, and 3.

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

Domain Valuation: Supporting information may be included in the addendums.

a. **Approach/Methodology:** Please describe your approach for valuing this domain.
b. **Rationale/Justification:** Please describe your rationale for valuing this domain including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc.

Category 4: Population-Focused Measures *[Baylor Medical Center at Garland/121790303]*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$ 143,440	$ 0		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Domain 1 - Estimated Maximum Incentive Amount		$ 83,134	$ 71,145	$ 77,332
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1:10/1/ 2016-3/31/ 2017
Domain 2 - Estimated Maximum Incentive Amount		$ 83,134	$ 71,147	$ 77,334
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1: 10/1/ 2015-3/31/2016	1:10/1/ 2016-3/31/ 2017
Domain 3 - Estimated Maximum Incentive Amount			$ 71,147	$ 77,334
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Medication Management				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Domain 4 - Estimated Maximum Incentive		$ 83,134	$ 71,147	$ 77,334

Amount				
Domain 5: Emergency Department				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Domain 5 - Estimated Maximum Incentive Amount		$ 83,134	$ 71,147	$ 77,334
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$ 143,440	$ 332,546	$ 355,733	$ 386,668

Performing Provider Name: Baylor Medical Center at Irving

Texas Provider Identifier: 121776204

Baylor Medical Center at Irving will be reporting all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Baylor Medical Center at Irving healthcare reporting system indicates further refinement and definition will be required for some of the required metrics. The reporting system has the capability to track and report the required measurements but will require additional work to get the exact required specifications. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Domain #1 – Potentially Preventable Admissions (8 measures)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, 8 of the eight measurements are being tracked and reported at Baylor Medical Center at Irving. In addition, many regional DSRIP projects will provide interventions to Baylor Medical Center at Irving patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor Medical Center at Irving will expand the existing data collecting system, and optimize the old system for new reporting processes.
The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor Medical Center at Irving has chosen will be 10/1 to 3/31.

b. Describe how Category 4 measures relate to project(s)/outcomes(s) in Categories 1, 2, and 3.
The PPA domain in Category 4 has 8 components. Although the impact of the Baylor Medical Center at Irving's DSRIP projects on the PPA domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPA domain. The projects and outcomes listed below will help to reduce/prevent PPAs in patients who engage in these programs, are actively managed and have their conditions under control.
The table below summarizes the projects and outcomes that potentially relate to the PPA domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD1- PPA							
Cat 1, 2, & 3	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
121776204.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X	X		X	X	N/A	X	X
IT 1.7 Controlling high blood pressure					X	N/A		
IT 12.5 Influenza Vaccination rate						N/A		X
121776204.1.2 :Improve Access to Specialty Care- Expand Specialty care Services				X		N/A		
IT 11.1 Asthma management for underserved				X		N/A		
121776204.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X	X		X	X	N/A		
IT 1.10 Diabetes HbA1c poor control		X				N/A		
IT 1.11 Diabetes BP control		X				N/A		
IT 1.13 Diabetes Foot exam		X				N/A		
121776204.2.2: Establish/Expand a Patient Care Navigation Program- Care Connect	X	X	X	X	X	N/A		
121776204.2.3 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment	X	X	X	X		N/A	X	X
IT 11.1 Diabetes Management for underserved with BH diagnoses		X				N/A		
IT 11.3 improve utilization rate of clinical preventive services for BH			X			N/A		
121776204.2.4 : 2.12.2 – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)	X	X	X	X	X	N/A	X	X
IT-10.1: Quality of Life.	X	X	X	X	X	N/A	X	X
IT-10.2: Activities of Daily Living	X	X	X	X	X	N/A	X	X
121776204.2.5 : 2.11.3 – Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program	X	X	X	X	X	N/A	X	X
IT-1.2 Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs	X		X		X	N/A		
IT-1.4 Annual monitoring for patients on persistent medications– diuretic	X		X		X	N/A		
IT-1.5 Annual monitoring for patients on persistent medications- anticonvulsant			X			N/A		
IT-1.19 Antidepressant Medication Management	X	X	X	X	X	N/A	X	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPAs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPAs.

Domain Valuation: Supporting information may be included in the addendums.

a. Approach/Methodology: Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. Rationale/Justification: Please describe your rationale for valuing this domain.

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At , the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #2 – 30 Day Readmissions (7 measures)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, 7 of the seven measurements are being tracked and reported at Baylor Medical Center at Irving. In addition, many regional DSRIP projects will provide interventions to Baylor Medical Center at Irving patients in multiple areas, resulting in improvement of PPRs throughout all measurements in the Reporting Domain. One note is that PPRs are reported within Baylor Health Care System only. Thus, if a patient presents at a Baylor facility and then is readmitted at another provider's facility, we cannot capture that data.

Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor Medical Center at Irving will expand the existing data collecting system, and optimize the old system for new reporting processes.

The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor Medical Center at Irving has chosen will be 10/1 to 3/31.

b. Describe how Category 4 measures relate to projects/outcomes(s) in Categories 1, 2, and 3. The PPR domain in Category 4 has 7 components. Although the impact of the Baylor Medical Center at Irving's DSRIP projects on the PPR domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPR domain. The projects and outcomes listed below will help to reduce/prevent PPRs in patients who engage in these programs, are actively managed and have their conditions under control. The table below summarizes the projects and outcomes that potentially relate to the PPR domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD2- PPR						
Cat 1, 2, & 3	2.1	2.2	2.3	2.4	2.5	2.6	2.7
121776204.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X	X	X	X	X	N/A	X
IT 1.7 Controlling high blood pressure					X	N/A	
121776204.1.2 :Improve Access to Specialty Care- Expand Specialty care Services				X		N/A	
IT 11.1 Asthma management for underserved				X		N/A	
121776204.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X	X		X	X	N/A	
IT 1.10 Diabetes HbA1c poor control		X				N/A	
IT 1.11 Diabetes BP control		X				N/A	
IT 1.13 Diabetes Foot exam		X				N/A	
121776204.2.2: Establish/Expand a Patient Care Navigation Program- Care Connect	X	X	X	X	X	N/A	X
121776204.2.3 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment			X			N/A	
IT 11.1 Diabetes Management for underserved with BH diagnoses		X				N/A	
IT 11.3 improve utilization rate of clinical preventive services for BH			X			N/A	
121776204.2.4 : 2.12.2 – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)	X	X	X	X	X	N/A	X
IT-10.1: Quality of Life.	X	X	X	X	X	N/A	X
IT-10.2: Activities of Daily Living	X	X	X	X	X	N/A	X
121776204.2.5 : 2.11.3 – Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program	X	X	X	X	X	N/A	X

IT-1.2 Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs	X		X		X	N/A	X
IT-1.4 Annual monitoring for patients on persistent medications– diuretic	X		X		X	N/A	X
IT-1.5 Annual monitoring for patients on persistent medications- anticonvulsant			X			N/A	X
IT-1.19 Antidepressant Medication Management	X	X	X	X	X	N/A	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPRs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPRs.

Domain Valuation: Supporting information may be included in the addendums.

a. Approach/Methodology: Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. Rationale/Justification: Please describe your rationale for valuing this domain .

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor Medical Center at Irving, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #3 – Potentially Preventable Complications, PPC (1 measure, but 64 reportable metrics)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, many of the sixty four measurements are being tracked and reported at Baylor Medical Center at Irving. In addition, many regional DSRIP projects will provide interventions to Baylor Medical Center at Irving patients in multiple areas, resulting in improvement of PPCs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor Medical Center at Irving will expand the existing data collecting system, and optimize the old system for new reporting processes.

The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor Medical Center at Irving has chosen will be 10/1 to 3/31.

b. Describe how Category 4 measures relate to projects/outcomes(s) in Categories 1, 2, and 3. The PPC domain in Category 4 has 1 component with 64 reportable measures. Although the impact of the Baylor Medical Center at Irving's DSRIP projects on the PPC domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPC domain. The projects and outcomes listed below will help to reduce/prevent PPCs in patients who engage in these programs, are actively managed and have their conditions under control.

The table below summarizes the projects and outcomes that potentially relate to the PPC domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD3- PPCs
Cat 1, 2, & 3	
121776204.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X
IT 1.7 Controlling high blood pressure	X
121776204.1.2 :Improve Access to Specialty Care- Expand Specialty care Services	X
IT 11.1 Asthma management for underserved	X
IT 12.2 Cervical Cancer Screening	X
IT 12.3 Colorectal Cancer Screening	X
121776204.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X
IT 1.10 Diabetes HbA1c poor control	X
IT 1.11 Diabetes BP control	X
IT 1.13 Diabetes Foot exam	X
121776204.2.3 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment	X
IT 11.1 Diabetes Management for underserved with BH diagnoses	X
IT 11.3 improve utilization rate of clinical preventive services for BH	X
121776204.2.4 : 2.12.2 – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)	X

IT-10.1: Quality of Life.	X
IT-10.2: Activities of Daily Living	X
121776204.2.5 : 2.11.3 – Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program	X
IT-1.2 Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs	X
IT-1.4 Annual monitoring for patients on persistent medications– diuretic	X
IT-1.5 Annual monitoring for patients on persistent medications- anticonvulsant	X
IT-1.19 Antidepressant Medication Management	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPCs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPCs in the inpatient setting.

Domain Valuation: Supporting information may be included in the addendums.

a. Approach/Methodology: Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. Rationale/Justification: Please describe your rationale for valuing this domain

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor Medical Center at Irving, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #4 – Patient-Centered Healthcare (2 measures)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, 2 of the two measurements are being tracked and reported internally within the Baylor Healthcare System's Office of Patient Centeredness and Quality Reporting and Analytics

departments. Although Baylor Medical Center at Irving does not have any projects directly related to patient satisfaction in the inpatient realm, one of our care navigation projects will most likely positively impact inpatient patient satisfaction. Baylor Medical Center at Irving will expand existing data collecting systems, and optimize the old system for new reporting processes.

b. Describe how Category 4 measures relate to projects/outcomes(s) in Categories 1, 2, and 3. Baylor Medical Center at Irving does not have any projects that directly address patient satisfaction measures in the inpatient setting. We do have projects in the ambulatory realm which will measure the impact of patient satisfaction. Additionally, we do have a project that focuses on medication management (121776204.2.5); however this project occurs in an outpatient setting and would not impact inpatient measures. We believe that the Care Connect project mentioned in the table below will help improve patient satisfaction scores in the inpatient setting through providing care coordination and continuity of care services.

Category 4	RD4- IP Pat Sat	
Cat 1, 2, & 3	4.1	4.2
121776204.2.3: Establish/Expand a Patient Care Navigation Program-Care Connect	X	X
IT 9.2 ED appropriate utilization	X	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect to see improvements in patient satisfaction for those patients who have engaged in the Care Connect program. Historically, we have not measured this impact of the program and thus do not have any data on the direct impact on patient satisfaction.

Domain Valuation: Supporting information may be included in the addendums.

a. Approach/Methodology: Please describe your approach for valuing this domain.
All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. Rationale/Justification: Please describe your rationale for valuing this domain including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor Medical Center at Irving, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #5 – Emergency Department (1 measure)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Baylor Medical Center at Irving has the data infrastructure and processes to track admit decision time to discharge. Some modification may be required to satisfy the requirement of new reporting domain.

b. Describe how Category 4 measures relate to project(s)/outcomes(s) in Categories 1, 2, and 3.

This domain only has 1 component which measures the time between admit decision to discharge in the ED. The majority of our projects are not physically located in the hospital other than our Care Connect program. We anticipate that if a patient is identified as a candidate for Care Connect in the ED, they can be triaged to community based or non-hospital based resource more quickly, leading to a shorter admit to discharge time duration.

Category 4	RD5- ED
121776204.2.3: Establish/Expand a Patient Care Navigation Program-Care Connect	X
IT 5.1 Improve cost savings	
IT 9.2 ED appropriate utilization	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that as the Care Connect program develops and expands that the time patients spend in the ED will decrease. Care Connect entails a comprehensive care coordination and case management system which can help to move patients to appropriate care settings more quickly.

Domain Valuation: Supporting information may be included in the addendums.

a. **Approach/Methodology:** Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. **Rationale/Justification:** Please describe your rationale for valuing this domain including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor Medical Center at Irving, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Option Domain #6 – Initial Core Set of Health Care Quality Measures (minimum of 12 measures listed in HHSC guidance. If additional measures are proposed, please describe in the narrative and list them in the table below). Optional, but required if requesting maximum Category Valuation of 15%.

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

b. Describe how Category 4 measures relate to project(s)/outcomes(s) in Categories 1, 2, and 3.

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

Domain Valuation: Supporting information may be included in the addendums.

a. **Approach/Methodology:** Please describe your approach for valuing this domain.

b. **Rationale/Justification:** Please describe your rationale for valuing this domain including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc

Category 4: Population-Focused Measures *[Baylor Medical Center at Irving/121776204]*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$ 116,549	$ 0		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Domain 1 - Estimated Maximum Incentive Amount		$ 67,548	$ 57,808	$ 62,835
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1:10/1/ 2016-3/31/ 2017
Domain 2 - Estimated Maximum Incentive Amount		$ 67,548	$ 57,808	$ 62,835
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1: 10/1/ 2015-3/31/2016	1:10/1/ 2016-3/31/ 2017
Domain 3 - Estimated Maximum Incentive Amount			$ 57,808	$ 62,835
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Medication Management				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017

Domain 4 - Estimated Maximum Incentive Amount		$ 67,548	$ 57,808	$ 62,835
Domain 5: Emergency Department				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Domain 5 - Estimated Maximum Incentive Amount		$ 67,547	$ 57,809	$ 62,835
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$ 116,549	$ 270,192	$ 289,040	$ 314,175

Performing Provider Name: Baylor University Medical Center

Texas Provider Identifier: 139485012

Baylor University Medical Center will be reporting all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Baylor University Medical Center healthcare reporting system indicates further refinement and definition will be required for some of the required metrics. The reporting system has the capability to track and report the required measurements but will require additional work to get the exact required specifications. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Domain #1 – Potentially Preventable Admissions (8 measures)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, 8 of the eight measurements are being tracked and reported at Baylor University Medical Center. In addition, many regional DSRIP projects will provide interventions to Baylor University Medical Center patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor University Medical Center will expand the existing data collecting system, and optimize the old system for new reporting processes. The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor University Medical Center has chosen will be 10/1 to 3/31.

b. Describe how Category 4 measures relate to project(s)/outcomes(s) in Categories 1, 2, and 3.

The PPA domain in Category 4 has 8 components. Although the impact of the Baylor University Medical Center's DSRIP projects on the PPA domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPA domain. The projects and outcomes listed below will help to reduce/prevent PPAs in patients who engage in these programs, are actively managed and have their conditions under control. The table below summarizes the projects and outcomes that potentially relate to the PPA domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD1- PPA							
Cat 1, 2, & 3	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
13945012.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X	X		X	X	N/A	X	X
IT 1.7 Controlling high blood pressure					X	N/A		
IT 12.5 Influenza Vaccination rate						N/A		X
13945012.1.2 :Improve Access to Specialty Care- Expand Specialty care Services				X		N/A		
IT 11.1 Asthma management for underserved				X		N/A		
13945012.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X	X		X	X	N/A		
IT 1.10 Diabetes HbA1c poor control		X				N/A		
IT 1.11 Diabetes BP control		X				N/A		
IT 1.13 Diabetes Foot exam		X				N/A		
13945012.2.2: Establish/Expand a Patient Care Navigation Program- Care Connect	X	X	X	X	X	N/A		
13945012.2.3 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment	X	X	X	X		N/A	X	X
IT 11.1 Diabetes Management for underserved with BH diagnoses		X				N/A		
IT 11.3 improve utilization rate of clinical preventive services for BH			X			N/A		
13945012.2.4 : 2.12.2 – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)	X	X	X	X	X	N/A	X	X
IT-10.1: Quality of Life.	X	X	X	X	X	N/A	X	X
IT-10.2: Activities of Daily Living	X	X	X	X	X	N/A	X	X
13945012.2.5 : 2.11.3 – Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program	X	X	X	X	X	N/A	X	X
IT-1.2 Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs	X		X		X	N/A		
IT-1.4 Annual monitoring for patients on persistent medications– diuretic	X		X		X	N/A		
IT-1.5 Annual monitoring for patients on persistent medications- anticonvulsant			X			N/A		

IT-1.19 Antidepressant Medication Management	X	X	X	X	X	N/A	X	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPAs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPAs.

Domain Valuation: Supporting information may be included in the addendums.

a. Approach/Methodology: Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. Rationale/Justification: Please describe your rationale for valuing this domain .

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At , the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #2 – 30 Day Readmissions (7 measures)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, 7 of the seven measurements are being tracked and reported at Baylor University Medical Center. In addition, many regional DSRIP projects will provide interventions to Baylor University Medical Center patients in multiple areas, resulting in improvement of PPRs throughout all measurements in the Reporting Domain. One note is that PPRs are reported within Baylor Health Care System only. Thus, if a patient presents at a Baylor facility and then is readmitted at another provider's facility, we cannot capture that data.

Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor University Medical Center will expand the existing data collecting system, and optimize the old system for new reporting processes.

The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor University Medical Center has chosen will be 10/1 to 3/31.

b. Describe how Category 4 measures relate to projects/outcomes(s) in Categories 1, 2, and 3.
The PPR domain in Category 4 has 7 components. Although the impact of the Baylor University Medical Center's DSRIP projects on the PPR domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPR domain. The projects and outcomes listed below will help to reduce/prevent PPRs in patients who engage in these programs, are actively managed and have their conditions under control. The table below summarizes the projects and outcomes that potentially relate to the PPR domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD2- PPR						
Cat 1, 2, & 3	2.1	2.2	2.3	2.4	2.5	2.6	2.7
13945012.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X	X	X	X	X	N/A	X
IT 1.7 Controlling high blood pressure					X	N/A	
13945012.1.2 :Improve Access to Specialty Care- Expand Specialty care Services				X		N/A	
IT 11.1 Asthma management for underserved				X		N/A	
13945012.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X	X		X	X	N/A	
IT 1.10 Diabetes HbA1c poor control		X				N/A	
IT 1.11 Diabetes BP control		X				N/A	
IT 1.13 Diabetes Foot exam		X				N/A	
13945012.2.2: Establish/Expand a Patient Care Navigation Program- Care Connect	X	X	X	X	X	N/A	X
13945012.2.3 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment			X			N/A	
IT 11.1 Diabetes Management for underserved with BH diagnoses		X				N/A	
IT 11.3 improve utilization rate of clinical preventive services for BH			X			N/A	
13945012.2.4 : 2.12.2 – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)	X	X	X	X	X	N/A	X
IT-10.1: Quality of Life.	X	X	X	X	X	N/A	X
IT-10.2: Activities of Daily Living	X	X	X	X	X	N/A	X

13945012.2.5 : 2.11.3 – Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program	X	X	X	X	X	N/A	X
IT-1.2 Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs	X		X		X	N/A	X
IT-1.4 Annual monitoring for patients on persistent medications– diuretic	X		X		X	N/A	X
IT-1.5 Annual monitoring for patients on persistent medications- anticonvulsant			X			N/A	X
IT-1.19 Antidepressant Medication Management	X	X	X	X	X	N/A	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPRs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPRs.

Domain Valuation: Supporting information may be included in the addendums.

a. Approach/Methodology: Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. Rationale/Justification: Please describe your rationale for valuing this domain .

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor University Medical Center, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #3 – Potentially Preventable Complications, PPC (1 measure, but 64 reportable metrics)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, many of the sixty four measurements are being tracked and reported at Baylor University Medical Center. In addition, many regional DSRIP projects will provide interventions to Baylor University Medical Centerpatients in multiple areas, resulting in improvement of PPCs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor University Medical Centerwill expand the existing data collecting system, and optimize the old system for new reporting processes. The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor University Medical Centerhas chosen will be 10/1 to 3/31.

b. Describe how Category 4 measures relate to projects/outcomes(s) in Categories 1, 2, and 3. The PPC domain in Category 4 has 1 component with 64 reportable measures. Although the impact of the Baylor University Medical Center's DSRIP projects on the PPC domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPC domain. The projects and outcomes listed below will help to reduce/prevent PPCs in patients who engage in these programs, are actively managed and have their conditions under control.

The table below summarizes the projects and outcomes that potentially relate to the PPC domain. Whether marked improvement will occur at a population level is uncertain.
f

Category 4	RD3- PPCs
Cat 1, 2, & 3	
13945012.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X
IT 1.7 Controlling high blood pressure	X
13945012.1.2 :Improve Access to Specialty Care- Expand Specialty care Services	X
IT 11.1 Asthma management for underserved	X
IT 12.2 Cervical Cancer Screening	X
IT 12.3 Colorectal Cancer Screening	X
13945012.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X
IT 1.10 Diabetes HbA1c poor control	X
IT 1.11 Diabetes BP control	X
IT 1.13 Diabetes Foot exam	X
13945012.2.3 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment	X

IT 11.1 Diabetes Management for underserved with BH diagnoses	X
IT 11.3 improve utilization rate of clinical preventive services for BH	X
13945012.2.4 : 2.12.2 – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or defined patient population: Early follow-up such as homecare visits primary care outreach/patient call-backs- Vulnerable Patient Network (Home Visit Program)	X
IT-10.1: Quality of Life.	X
IT-10.2: Activities of Daily Living	X
13945012.2.5 : 2.11.3 – Other Project Option- Evidence Based Interventions that put in place teams, technology and processes to ensure medication compliance and management- Medication Management and Prescription Assistance Program	X
IT-1.2 Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs	X
IT-1.4 Annual monitoring for patients on persistent medications– diuretic	X
IT-1.5 Annual monitoring for patients on persistent medications- anticonvulsant	X
IT-1.19 Antidepressant Medication Management	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPCs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPCs in the inpatient setting. We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPCs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPCs in the inpatient setting. For example, helping a patient control their diabetes in the outpatient setting may help to reduce PPC # 26: Diabetic Ketoacidosis and Coma or PPC #38 Post-Operative Infection and Deep Wound Disruption with Procedure (if a patient has well controlled diabetes, they may be less susceptible to post-operative infections).The correlation between outpatient management and PPCs is weak and the overall impact of outpatient interventions on PPCs may be minimal.

Domain Valuation: Supporting information may be included in the addendums.

a. Approach/Methodology: Please describe your approach for valuing this domain.

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. Rationale/Justification: Please describe your rationale for valuing this domain

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor University Medical Center, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #4 – Patient-Centered Healthcare (2 measures)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Currently, 2 of the two measurements are being tracked and reported internally within the Baylor Healthcare System's Office of Patient Centeredness and Quality Reporting and Analytics departments. Although Baylor University Medical Center does not have any projects directly related to patient satisfaction in the inpatient realm, one of our care navigation projects will most likely positively impact inpatient patient satisfaction. Baylor University Medical Center will expand existing data collecting systems, and optimize the old system for new reporting processes.

b. Describe how Category 4 measures relate to projects/outcomes(s) in Categories 1, 2, and 3.

Baylor University Medical Center does not have any projects that directly address patient satisfaction measures in the inpatient setting. We do have projects in the ambulatory realm which will measure the impact of patient satisfaction. Additionally, we do have a project that focuses on medication management (139485012.2.5); however this project occurs in an outpatient setting and would not impact inpatient measures. We believe that the Care Connect project mentioned in the table below will help improve patient satisfaction scores in the inpatient setting through providing care coordination and continuity of care services.

Category 4	RD4- IP Pat Sat	
Cat 1, 2, & 3	4.1	4.2
13945012.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect	X	X

IT 9.2 ED appropriate utilization	X	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect to see improvements in patient satisfaction for those patients who have engaged in the Care Connect program. Historically, we have not measured this impact of the program and thus do not have any data on the direct impact on patient satisfaction.

Domain Valuation: Supporting information may be included in the addendums.

a. Approach/Methodology: Please describe your approach for valuing this domain.
All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. Rationale/Justification: Please describe your rationale for valuing this domain including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor University Medical Center, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Domain #5 – Emergency Department (1 measure)

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

Baylor University Medical Center has the data infrastructure and processes to track admit decision time to discharge. Some modification may be required to satisfy the requirement of new reporting domain.

b. Describe how Category 4 measures relate to projects/outcomes(s) in Categories 1, 2, and 3.

This domain only has 1 component which measures the time between admit decision to discharge in the ED. The majority of our projects are not physically located in the hospital other than our Care Connect program. We anticipate that if a patient is identified as a candidate for Care Connect in the ED, they can be triaged to community based or non-hospital based resource more quickly, leading to a shorter admit to discharge time duration. ‘

Category 4	RD5- ED
13945012.2.3: Establish/Expand a Patient Care Navigation Program-Care Connect	X
IT 5.1 Improve cost savings	
IT 9.2 ED appropriate utilization	X

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

We expect that as the Care Connect program develops and expands that the time patients spend in the ED will decrease. Care Connect entails a comprehensive care coordination and case management system which can help to move patients to appropriate care settings more quickly.

Domain Valuation: Supporting information may be included in the addendums.

a. **Approach/Methodology:** Please describe your approach for valuing this domain.
All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

b. **Rationale/Justification:** Please describe your rationale for valuing this domain including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor University Medical Center, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Option Domain #6 – Initial Core Set of Health Care Quality Measures (minimum of 12 measures listed in HHSC guidance. If additional measures are proposed, please describe in the narrative and list them in the table below). Optional, but required if requesting maximum Category Valuation of 15%.

Domain Description:

a. Describe the system capability changes needed for reporting and specify measuring and reporting periods.

b. Describe how Category 4 measures relate to projects/outcomes(s) in Categories 1, 2, and 3.

c. Describe the expected improvements for DYs 2-5. Indicate if a domain measure is exempt and state the reason.

Domain Valuation: Supporting information may be included in the addendums.

a. **Approach/Methodology:** Please describe your approach for valuing this domain.

b. **Rationale/Justification:** Please describe your rationale for valuing this domain including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc.

Category 4: Population-Focused Measures *[Baylor University Medical Center/139485012]*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$ 673,510	$ 0		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/2015-3/31/2016	1: 10/1/2016-3/31/2017
Domain 1 - Estimated Maximum Incentive Amount		$ 390,345	$ 334,062	$ 363,111
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/2015-3/31/2016	1: 10/1/2016-3/31/2017
Domain 2 - Estimated Maximum Incentive Amount		$ 390,345	$ 334,062	$ 363,111
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1: 10/1/2015-3/31/2016	1: 10/1/2016-3/31/2017
Domain 3 - Estimated Maximum Incentive Amount			$ 334,062	$ 363,111
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/2015-3/31/2016	1: 10/1/2016-3/31/2017
Medication Management				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/2015-3/31/2016	1: 10/1/2016-3/31/2017

Domain 4 - Estimated Maximum Incentive Amount		$ 390,343	$ 334,062	$ 363,111
Domain 5: Emergency Department				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/2015-3/31/2016	1: 10/1/2016-3/31/2017
Domain 5 - Estimated Maximum Incentive Amount		$ 390,343	$ 334,062	$ 363,112
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount				
Grand Total Payments Across Category 4	$ 673,510	$ 1,561,376	$ 1,670,310	$ 1,815,556

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807
Unique RHP identification number: 138910807.4.1

Domain Descriptions:

Children's has been reporting and tracking the RD1 measures through Child Health Corporation of America (CHCA) for comparison with other stand-alone pediatric hospitals.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of current the current reporting system will occur during DY2 and DY3 to optimize system compatibility and to meet new reporting requirements. New processes will be implemented to ensure complete and accurate data collection. Category 1 and 2 projects and Category 3 outcomes baseline values will use available data to establish baseline and milestone metrics.

Children's successful implementation of Category 1 interventions will lead to health care improvements during and after the waiver period including reducing potentially preventable admissions. Opening new MyChildren's locations (138910807.1.1) and expanding MyChildren's hours at in RHP 9 (138910807.1.2) will improve access to care by making more primary care office hours available and also outside of the regular office hours. Potentially Preventable Admissions can be avoided with regular primary care. Children with complex chronic medical conditions often are hospitalized due to poor coordination of care and the complications of one treatment impacting another organ system. Providing a medical home for these patients will support effective coordination of care and avoid potentially preventable admissions. Studies have shown that use of a pediatric nurse triage phone system (138910807.1.2) can reduce unnecessary trips to the emergency room by two thirds of those families using the phone system while increasing the use of the emergency department or urgent care in 15% of families using the triage nurse line and who would have otherwise stayed at home. Appropriate escalation of care to the most effective setting will decrease Potentially Preventable Admissions. By implementing disease management programs in the MyChildren's practices (138910807.1.3), chronic diseases such as asthma can be managed locally with exacerbations of symptoms reduced and thus Potentially Avoidable Admissions prevented. Access to behavioral health services in the MyChildren's locations (138910807.1.4) will also decrease Potentially Preventable Admissions, particularly when coupled with disease management for chronic illness. Children with chronic illness are at much higher risk of increased incidence of mental illness which can result increased inpatient admissions.

The Category 2 project to transform the MyChildren's primary care offices into patient-centered medical homes certified by the NCQA (138910807.2.1) will provide timely, effective, culturally sensitive primary care services which will reduce Potentially Preventable Admissions by proactively identifying and treating health issues which could result in hospital admissions.

Patients with complex medical needs requiring coordination of services and patients who habitually use the emergency services for low complexity care will be provided patient navigation services (138910807.2.2) which will assist patients in seeking care at an appropriate setting at an appropriate time thus preventing escalation of illness which would result in a potentially preventable admission. Addressing the overall health of the community and specifically targeting pediatric asthma (138910807.2.3) will increase awareness of appropriate management and ultimate prevention of these health conditions. Providing a standardized approach to transitioning older pediatric patients to adult providers (138910807.2.4) will assure continuation of care to avoid potentially preventable admissions during transition of care.

Improvements in Category 3 outcomes will influence the Category 4 reporting measures by proactively and effectively treating health concerns to avoid escalation of care needs including emergency room use and hospital admissions.

All Category 1 and 2 projects and Category 3 outcome measures will support reductions in Category 4 reporting measures including Potentially Preventable Admissions.

Children's will report on all pediatric-appropriate measures in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
As per HHSC and CMS guidelines, Children's has valued Category 4 at the maximum allowed values of 10% for DY2 and 15% for DY3, DY4 and DY5. This maximum valuation reflects Children's commitment to providing data to document and influence pediatric healthcare outcomes.

Reporting Domain 2: Potentially Preventable Readmissions:

Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807
Unique RHP identification number: 138910807.4.2

Domain Descriptions:

Children's has been reporting and tracking the RD2 measures through Child Health Corporation of America (CHCA) for comparison with other stand-alone pediatric hospitals.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of current the current reporting system will occur during DY2 and DY3 to optimize system compatibility and to meet new reporting requirements. New processes will be implemented to ensure complete and accurate data collection. Category 1 and 2 projects and Category 3 outcomes baseline values will use available data to establish baseline and milestone metrics.

Children's successful implementation of Category 1 interventions will lead to health care improvements for pediatric patients during and after the waiver period including long-term health improvements into adulthood and reduce potentially preventable readmissions. It is important that children receive appropriate outpatient follow-up care a hospitalization. Anecdotally, discharges at Children's are often delayed due to the need to secure an outpatient follow-up appointment post-discharge, particularly for those patients on Medicaid, CHIP or uninsured. New MyChildren's offices (138910807.1.1) will be placed in locations where there are limited number or no pediatricians who accept Medicaid or CHIP. The placement of a MyChildren's office on the Dallas Children's Medical Center campus will provide access to primary care on the same campus where the child was initially hospitalized. Children with chronic complex medical needs will also have access to a primary care office on the Dallas campus. Expanding MyChildren's hours (138910807.1.2) will make more appointments available at times convenient to parents thus increasing the ability to make a follow-up appointment post-discharge and lessen the potential for a preventable readmission. Studies have shown that use of a pediatric nurse triage phone system (138910807.1.2) can increase the use of the emergency department or urgent care in 15% of families using the triage line who would have otherwise stayed at home, unaware of the urgency of their child's medical condition. Appropriate escalation of care to the most effective setting post inpatient discharge will decrease the Potentially Preventable Readmissions. Many children are hospitalized for chronic disease conditions. Children can be enrolled in the disease management program through the MyChildren's practices in RHP 9 (138910807.1.3) during their inpatient stay. Post discharge, the chronic condition such as asthma can be managed locally with exacerbations of symptoms reduced and thus Potentially Avoidable Readmissions prevented. Access to behavioral health services in the MyChildren's (138910807.1.4) will also decrease Potentially Preventable Readmissions, particularly when coupled with disease management for chronic illness. Children with chronic illness are at much higher risk of increased incidence of mental illness which can result increased inpatient admissions.

The Category 2 project to transform the MyChildren's primary care offices into patient-centered medical homes certified by the NCQA (138910807.2.1) will provide timely, effective, culturally sensitive primary care services. Since the medical home is designed to manage a child's medical condition holistically, missed follow-up appointments post discharge will be flagged for further contact with the family. Also, the medical home practice will be proactively following patients who have had a recent inpatient stay, thereby reducing Potentially Preventable Readmissions. Patients with complex medical needs requiring coordination of services and patients who habitually use the emergency services for low complexity care will be provided patient navigation services (138910807.2.2) which will assist patients in seeking care at an appropriate setting at an appropriate time thus preventing escalation of illness which would result in a potentially preventable readmission.

Improvements in Category 3 outcomes will influence the Category 4 reporting measures by proactively and effectively treating health concerns to avoid escalation of care needs including emergency room use and hospital admissions and readmissions.

All Category 1 and 2 projects and Category 3 outcome measures will support reductions in Category 4 reporting measures including Potentially Preventable Readmissions.

Children's will report on all pediatric-appropriate measures in RD2 in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
As per HHSC and CMS guidelines, Children's has valued Category 4 at the maximum allowed values of 10% for DY2 and 15% for DY3, DY4 and DY5. This maximum valuation reflects Children's commitment to providing data to document, influence and improve pediatric healthcare outcomes.

Reporting Domain 3: Potentially Preventable Complications:

Performing Provider Name/TPI: Children's Medical Center of Dallas/13890807
Unique RHP identification number: 13890807.4.3

Domain Descriptions:

Children's has been reporting and tracking the RD3 measures through Child Health Corporation of America (CHCA) for comparison with other stand-alone pediatric hospitals.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of current the current reporting system will occur during DY2 and DY3 to optimize system compatibility and to meet new reporting requirements. New processes will be implemented to ensure complete and accurate data collection. Category 1 and 2 projects and Category 3 outcomes baseline values will use available data to establish baseline and milestone metrics.

There are no specific Category 1 or 2 projects being proposed by Children's which directly will influence Potentially Preventable Complications. However, Children's successful implementation of Category 1 and Category 2 interventions will lead to health care improvements for pediatric patients during and after the waiver period including long-term health improvements into adulthood. One of the outcomes of the Category 1 and Category 2 interventions will be a more health-literate patient and family. Teaching families to be the advocates for their children's health will be of part of a patient-centered medical home (138910807.2.1), disease management (138910807.1.3) and behavioral health services (138910807.1.4). Families who are an active member of their child's health care team when that child is hospitalized can greatly influence and reduce Potentially Preventable Complications by questioning care providers and escalating concerns to receive appropriate intervention. By expanding MyChildren's hours and adding another location in RHP 18 (138910807.1.1 and 138910807.1.2) and making more appointments available at times convenient to parents, the

likelihood of a potentially avoidable admission is decreased thereby eliminating potentially preventable complications during an inpatient stay. Studies have shown that use of a pediatric nurse triage phone system (138910807.1.3) can increase the use of the emergency department or urgent care in 15% of families who would have otherwise stayed at home, unaware of the urgency of their child's medical condition. Appropriate escalation of care to the most effective setting will decrease the potentially preventable admissions thereby eliminating the potential for complications during an inpatient stay.

Improvements in Category 3 outcomes will influence the Category 4 reporting measures by proactively and effectively treating health concerns to avoid escalation of care needs including emergency room use and hospital admissions and readmissions.

All Category 1 and 2 projects and Category 3 outcome measures will support reductions in Category 4 reporting measures by improving health and patient/family health advocacy thereby reducing potentially preventable complications during an inpatient stay.

Children's will report on all pediatric-appropriate measures in RD3 in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
As per HHSC and CMS guidelines, Children's has valued Category 4 at the maximum allowed values of 10% for DY2 and 15% for DY3, DY4 and DY5. This maximum valuation reflects Children's commitment to providing data to document, influence and improve pediatric healthcare outcomes.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807
Unique RHP identification number: 138910807.4.4

Domain Descriptions:

Children's has been reporting and tracking these statistics through Child Health Corporation of America (CHCA) for comparison with other stand-alone pediatric hospitals.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of current the current reporting system will happen during DY2 and DY3 to optimize system compatibility and to meet new reporting requirements. New processes will be implemented to ensure complete and accurate data collection. Category 1 and 2 projects and Category 3 outcomes baseline values will use available data to establish baseline and milestone metrics.

There are no specific Category 1 or 2 projects being proposed by Children's which directly influence patient satisfaction with an inpatient stay or medication reconciliation at the time of discharge. However, Children's successful implementation of Category 1 and Category 2 interventions will lead to improvements for pediatric patients during and after the waiver period including long-term health improvements into adulthood. One of the outcomes of the Category 1 and Category 2 interventions will be a more health-literate patient and family. Teaching families to be the advocates for their children's health will be of part of a patient-centered medical home (138910807.2.1), disease management (138910807.1.3) and behavioral health services (138910807.1.4). Families who are an active member of their child's health care team when that child is hospitalized are more satisfied with the care their child received while hospitalized and will be proactive in requesting medication reconciliation at discharge.

Improvements in Category 3 outcomes will influence the Category 4 reporting measures by proactively and effectively treating health concerns to avoid escalation of care needs including emergency room use and hospital admissions and readmissions.

All Category 1 and 2 projects and Category 3 outcome measures will support reductions in Category 4 reporting measures by improving health and patient/family health advocacy thereby patient and family satisfaction and medication management during an inpatient stay.

Children's will report on all pediatric-appropriate measures in RD4 in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
As per HHSC and CMS guidelines, Children's has valued Category 4 at the maximum allowed values of 10% for DY2 and 15% for DY3, DY4 and DY5. This maximum valuation reflects Children's commitment to providing data to document, influence and improve pediatric healthcare outcomes.

Reporting Domain 5: Emergency Department:

Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807
Unique RHP identification number: 138910807.4.5

Domain Descriptions:

There are no DSRIP projects associated with this reporting domain and therefore no measureable impact is expected for this domain related to the interventions.

Children's will report on the required measures annually starting in DY3.

Domain Valuation:

As per HHSC and CMS guidelines, Children's has valued Category 4 at the maximum allowed values of 10% for DY2 and 15% for DY3, DY4 and DY5. This maximum valuation reflects Children's commitment to providing data to document and influence pediatric healthcare outcomes.

Reporting Domain 6: Children and Adult Core Measures

Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807
Unique RHP identification number: 138910807.4.6

Domain Descriptions:
Children's will participate in the optional Reporting Domain with separated measurement sets for children and adults. Since Children's is a pediatric facility, limited information will be available for the adult data set.
Children's does not provide prenatal or birthing services, therefore Measure 1 through 4 of the Initial Core Set of Children's Health Care Quality Measures will not be influenced by Children's DSRIP projects. Category 1 interventions 138910807.1.1, 138910807.1.2 and Category 2 intervention 138910807.2.1 are based in the primary care environment and will positively influence Measures 5 through 18. Category 1 intervention 138910807.1.3 provides expansion of disease management services and will positively influence Measures 20 and 22. Category 1 intervention 138910807.1.4 will increase behavioral health services and will positively impact Measures 21 and 23. The DSRIP projects are all designed to improve patient and family satisfaction and therefore should positively influence Measure 24. The DSRIP projects will not directly address Measure 19.

Children's will report on the required measures annually starting in DY3.

Domain Valuation:
As per HHSC and CMS guidelines, Children's has valued Category 4 at the maximum allowed values of 10% for DY2 and 15% for DY3, DY4 and DY5. This maximum valuation reflects Children's commitment to providing data to document and influence pediatric healthcare outcomes.

Category 4: Population-Focused Measures *Children's Medical Center 138910807*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$1,527,294	$885,166		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$885,166	$946,922	$1,029,236
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$885,166	$946,922	$1,029,263
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			$946,922	$1,029,263
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1-1-2013 – 12-31-2013	1-1-2014 – 12-31-2014	1-12015 – 12-31-2015
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		1-1-2013 – 12-31-2013	1-1-2014 – 12-31-2014	1-12015 – 12-31-2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$885,166	$946,922	$1,029,263
Domain 5: Emergency Department				
Measurement period for report		1-1-2013 – 12-31-2013	1-1-2014 – 12-31-	1-12015 – 12-31-

			2014	2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$885,166	$946,922	$1,029,263
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		1-1-2013 – 12-31-2013	1-1-2014 – 12-31-2014	1-12015 – 12-31-2015
Planned Reporting Period: 1 or 2		2	2	2
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		1-1-2013 – 12-31-2013	1-1-2014 – 12-31-2014	1-12015 – 12-31-2015
Planned Reporting Period: 1 or 2		~~2~~	~~2~~	~~2~~
Domain 6 - Estimated Maximum Incentive Amount		$885,170	$946,926	$1,029,294
Grand Total Payments Across Category 4	$1,527,294	$5,311,000	$5,681,536	$6,175,582

The IGT entities for each year are:

Dallas County Hospital District dba Parkland Hlth & Hosp Sys	127295703
Ector County Hospital District	135235306

Performing Provider Name: Denton Regional Medical Center

Texas Provider Identifier: 111905902

Denton Regional Medical Center will be reporting all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Denton Regional Medical Center healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Domain #1 – Potentially Preventable Admissions (8 measures)

Denton Regional Medical Center currently tracks and reports 2 of the 8 measurements for public reporting. Measurements that have not yet been addressed are:

- Congestive heart Failure Admission Rate
- Diabetes Admission Rates
- Behavioral Health and Substance Abuse Admission Rate
- Chronic Obstructive Pulmonary Disease or Asthma in Adults
- Admission Rate
- Hypertension Admission rate
- Pediatric Asthma

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, Denton Regional Medical Center will expand existing data collecting system and optimize old system for new reporting processes.

The proposed project to Redesign Patient Experience 111905902.2.2 is intended to implement process improvements to change the patient satisfaction and experience utilizing the hospital. This will impact inpatient and outpatient services. Key areas of experience can influence the risk of admission, including communication, care from nurses and doctors and medication management and discharge process. For example, patients in Emergency rooms need good instructions on their disease and medications and/or follow up care that is necessary. The potential exists for patients to not follow the care prescribed because they don't understand the impact of these instructions as it was not communicated effectively. Better communication can assist in preventing an health care issue from becoming acute and requiring hospitalization, In particular, how well the staff communicates with patients about medications, and whether key information is provided at discharge can directly impact the risk of admission for patients.

Domain Valuation:
The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #2 – 30 Day Readmissions (7 measures)

Denton Regional Medical Center currently tracks and reports 2 of the 7 measurements for public reporting. Measurements that have not yet been addressed are:

- Diabetes: 30-Day Readmissions
- Behavioral Health & Substance Abuse: 30-Day Readmissions
- Chronic Obstructive Pulmonary Disease (COPD): 30-Day
- Readmissions
- Stroke: 30- Day Readmissions
- Pediatric Asthma: 30-Day Readmissions

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, Denton Regional Medical Center will expand existing data collecting system and optimize old system for new reporting processes.

In addition, DSRIP projects will provide interventions to Denton Regional Medical Center patients in multiple areas, resulting in improvement of PPRs throughout all measurements in the Reporting Domain.

The proposed project to Redesign Patient Experience is intended to implement process improvements to change the patient satisfaction and experience of hospitalization. Key areas of experience can influence the risk of readmission, including communication, care from nurses and doctors and medication management and discharge process. In particular, how well the staff communicates with patients about medications, and whether key information is provided at discharge can directly impact the risk of readmission for patients.

In addition, the proposed project 111905902.2.1 for Sepsis improvement involves the timely identification/diagnosis of sepsis and evidence based treatment for patients. It is also important for Sepsis patients to be placed on the right medications (right antibiotics, vasopressors, etc.) as a part of evidence based care. To ensure patients know what medications they were on in the

hospital and what they must take after discharge, effective medication management is vital for continued care of sepsis and reduced risk for readmissions.

We also expect to see a reduction in readmissions for patients with an initial index admission of Sepsis and those readmitted for Sepsis with initial diagnosis other than Sepsis. Readmissions due to medication management will also be reduced.

Domain Valuation:
The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #3 – Potentially Preventable Complications, PPC (1 measure, but 64 reportable metrics)

Currently, 15 of the sixty four measurements are being tracked and reported in a form of public healthcare statistics. All other measures are tracked and reported internally

Currently, HHSC will make potentially preventable event data to providers. In addition, Denton Regional Medical Center will expand existing data collecting system and optimize old system for new reporting processes.

In addition, DSRIP projects will provide interventions to Denton Regional Medical Center patients in multiple areas, resulting in improvement of PPCs throughout all measurements in the Reporting Domain.
The proposed project to implement an innovative program for Sepsis improvement aims to identify /diagnosis Sepsis sooner and begin evidence based treatment to reduce mortality and complications for septic shock and severe sepsis.

Improved sepsis care reduces complications particularly those common in septic patients such as pulmonary embolism, acute myocardial infarction, venous thrombosis, major liver complications, renal failure with and without Dialysis and encephalopathy. Also, the project will focus on reducing the average length of stay for sepsis patients. Reducing the length of stay of patients diagnosed with sepsis will also impact a reduction in complications. Evidence shows with increased length of stay there is increased risk of preventable complications.

The proposed project to Redesign the Patient Experience will focus on patients satisfaction and experience. Improved patient communication and satisfaction with caregivers has been shown to improve quality and safety of care. Poor communications including nurse and doctor responses to patients has been correlated to increased beds sores, bloodstream infections, catheter-related Infections and leg or lung blood clots. A reduction in preventable complications is expected with a redesigned patient experience.

Domain Valuation:

The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #4 – Patient-Centered Healthcare (2 measures)

Currently, 2 of the two measurements are being tracked and reported.

Patient Satisfaction is surveyed by Gallup for HCAHPS requirements. It is reported internally each week for preliminary results. As required, final results are report to CMS and posted publically. Publicly reported HCAHPS results are based on four consecutive quarters of patient surveys. CMS publishes participating hospitals' HCAHPS results on the Hospital Compare website (www.hospitalcompare.hhs.gov) four times a year, with the oldest quarter of patient surveys rolling off as the most recent quarter rolls on. Additional HCAHPS results can be found on HCAHPS On-Line, (www.hcahpsonline.org).

Medication management is only reported publically as a required element of certain CORE MEASURES reporting. However, it is tracked and reported internally for all inpatients by the quality department as a patient safety and quality of care measurement.

Denton Regional Medical Center will expand existing data collecting system and optimize old system for new reporting processes as necessary.

In addition, Denton Regional Medical Center has proposed several quality-based projects that will provide improvement of care to all Denton Regional Medical Center patients in multiple

areas, resulting in improvement patient satisfaction throughout all measurements in the Reporting Domain.

The proposed project to Redesign Patient Experience is aimed at improving the patient satisfaction of the care received (RD-4 1. Patient Satisfaction).The goal to improve patient satisfaction and experience is also important for improved quality and safety of care provided. Studies have linked patient satisfaction with communication with doctor nurses, responsive to patients' needs and cleanliness to patient perceptions of hospital practices and facility infection rates.

Another focus for Redesign Patient Experience is medication management (RD-4 2 Medication Management). How well the staff communicates with patients about medicines, and whether key information is provided at discharge is critical to successful medication management and patient safety.

The proposed project for process improvement for Sepsis care involves the timely identification/diagnosis of sepsis and evidence based treatment for patients. Improving processes in this program includes effective communication. The communication between the emergency room, doctors, nurses/ care givers and families for these critically ill patients is vital to the plan of care. Teaching patients and families the cause and symptoms of sepsis is also important for care management. Patient satisfaction is improved with effective communication.

It is also important for Sepsis patients to be placed on the right medications (right antibiotics, vasopressors, etc.) as a part of evidence based care. To ensure patients know what medications they were on in the hospital and what they must take after discharge, effective medication management if vital for continued care of sepsis.

We expected to improve Patient satisfaction HCAHPS Grand Composite scores to be > 75th percentile by the end of the waiver. Although we are over 95% compliant with Medication Management documentation, we have only earned a 58% on the composite scores on Communication on medications in HCAHPS. We expect effective communication improvement will increase HCAHPS medication scores by 50% by the end of the waiver.

Domain Valuation:

The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #5 – Emergency Department (1 measure)

Denton Regional Medical Center currently tracks and reports Admit decision time to ED departure for admitted patients for JCAHO and internal quality requirements. The current tracking system is already in place and will be modified or improved as necessary to satisfy the requirement of new reporting domain.

In addition, the proposed project for Sepsis improvement involves the timely identification and evidence based treatment of patients. A key component of a Sepsis protocol is the timely identification/diagnosis of septic shock/severe sepsis to admit and begin evidence based treatment. Process improvements implemented for sepsis protocols in the ED support the goal of less than 1 hour for ED admit/ departure (decision time) for critical patients.

Domain Valuation:

The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Category 4: Population-Focused Measures *Denton Regional Medical Center/111905902*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$48,343	$22,414		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$22,415	$23,978	$26,082
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$22,414	$23,977	$26,083
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$23,977	$26,082
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		Calendar Year Jan 2013 – Dec 2013	Calendar Year Jan 2014- Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		Calendar Year Jan 2013 – Dec 2013	Calendar Year Jan 2014- Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$22,414	$23,977	$26,082
Domain 5: Emergency Department				
Measurement period for report		Calendar Year Jan 2013 – Dec 2013	Calendar Year Jan 2014- Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2

Domain 5 - Estimated Maximum Incentive Amount		$22,414	$23,977	$26,082
OPTIONAL Domain 6: Children and Adult Core Measures				
Children Core Measures				
Percentage of Live Births Weighing less than 2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean Rate for Nulliparous Singleton Vertex				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Ambulatory Care: Emergency Department Visits				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Central-Line Associated Bloodstream Infections – Neonatal Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adults Core Measures				
Plan All-Cause Readmission				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Diabetes, Short-term Complications Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
COPD Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
CHF Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adult Asthma Admission Rate				

Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective Delivery				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Antenatal Steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Care Transitions				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$48,343	$112,071	$119,886	$130,411

Category 4

Performing Provider Name: Las Colinas Medical Center

Texas Provider Identifier: 020979301

Las Colinas Medical Center will be reporting all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Las Colinas Medical Center healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Domain #1 – Potentially Preventable Admissions (8 measures)
Las Colinas Medical Center currently tracks and reports 2 of the 8 measurements for public reporting. Measurements that have not yet been addressed are:

- Congestive heart Failure Admission Rate
- Diabetes Admission Rates
- Behavioral Health and Substance Abuse Admission Rate
- Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rate
- Hypertension Admission rate
- Pediatric Asthma

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, Las Colinas Medical Center will expand existing data collecting system and optimize old system for new reporting processes.

The proposed project to Redesign Patient Experience 020979301.2.1 is intended to implement process improvements to change the patient satisfaction and experience of patients utilizing the hospital. This will impact inpatient and outpatient services. Key areas of experience can influence the risk of admission, including communication, care from nurses and doctors and medication management and discharge process. For example, patients in Emergency rooms need good instructions on their disease and medications and/or follow up care that is necessary. The potential exists for patients to not follow the care prescribed because they don't understand the impact of these instructions as it was not communicated effectively. Better communication can assist in preventing an health care issue from becoming acute and requiring hospitalization, In particular, how well the staff communicates with patients about medications,

and whether key information is provided at discharge can directly impact the risk of admission for patients.

Domain Valuation:
The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #2 – 30 Day Readmissions (7 measures)

Las Colinas Medical Center currently tracks and reports 2 of the 7 measurements for public reporting. Measurements that have not yet been addressed are:

- Diabetes: 30-Day Readmissions
- Behavioral Health & Substance Abuse: 30-Day Readmissions
- Chronic Obstructive Pulmonary Disease (COPD): 30-Day Readmissions
- Stroke: 30- Day Readmissions
- Pediatric Asthma: 30-Day Readmissions

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, Las Colinas Medical Center will expand existing data collecting system and optimize old system for new reporting processes.

In addition, DSRIP projects will provide interventions to Las Colinas Medical Center patients in multiple areas, resulting in improvement of PPRs throughout all measurements in the Reporting Domain.

The proposed project to Redesign Patient Experience is intended to implement process improvements to change the patient satisfaction and experience of hospitalization. Key areas of experience can influence the risk of readmission, including communication, care from nurses and doctors and medication management and discharge process. In particular, how well the staff communicates with patients about medications, and whether key information is provided at discharge can directly impact the risk of readmission for patients.

Domain Valuation:

The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #3 – Potentially Preventable Complications, PPC (1 measure, but 64 reportable metrics)

Currently, 15 of the sixty four measurements are being tracked and reported in a form of public healthcare statistics. All other measures are tracked and reported internally

Currently, HHSC will make potentially preventable event data to providers. In addition, Las Colinas Medical Center will expand existing data collecting system and optimize old system for new reporting processes.

In addition, DSRIP projects will provide interventions to Las Colinas Medical Center patients in multiple areas, resulting in improvement of PPCs throughout all measurements in the Reporting Domain.

The proposed project to Redesign the Patient Experience will focus on patients satisfaction and experience. Improved patient communication and satisfaction with caregivers has been shown to improve quality and safety of care. Poor communications including nurse and doctor responses to patients has been correlated to increased beds sores, bloodstream infections, catheter-related Infections and leg or lung blood clots. A reduction in preventable complications is expected with a redesigned patient experience.

Domain Valuation:

The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #4 – Patient-Centered Healthcare (2 measures)

Currently, 2 of the two measurements are being tracked and reported.

Patient Satisfaction is surveyed by Gallup for HCAHPS requirements. It is reported internally each week for preliminary results. As required, final results are report to CMS and posted publically. Publicly reported HCAHPS results are based on four consecutive quarters of patient surveys. CMS publishes participating hospitals' HCAHPS results on the Hospital Compare website (www.hospitalcompare.hhs.gov) four times a year, with the oldest quarter of patient surveys rolling off as the most recent quarter rolls on. Additional HCAHPS results can be found on HCAHPS On-Line, (www.hcahpsonline.org).

Medication management is only reported publically as a required element of certain CORE MEASURES reporting. However, it is tracked and reported internally for all inpatients by the quality department as a patient safety and quality of care measurement.

Las Colinas Medical Center will expand existing data collecting system and optimize old system for new reporting processes as necessary.

In addition, Las Colinas Medical Center has proposed a quality-based project that will provide improvement of care to all Las Colinas Medical Center patients in multiple areas, resulting in improvement patient satisfaction throughout all measurements in the Reporting Domain. The proposed project to Redesign Patient Experience is aimed at improving the patient satisfaction of the care received (RD-4 1. Patient Satisfaction).The goal to improve patient satisfaction and experience is also important for improved quality and safety of care provided. Studies have linked patient satisfaction with communication with doctor nurses, responsive to patients' needs and cleanliness to patient perceptions of hospital practices and facility infection rates.

Another focus for Redesign Patient Experience is medication management (RD-4 2 Medication Management). How well the staff communicates with patients about medicines, and whether key information is provided at discharge is critical to successful medication management and patient safety.

We expected to improve Patient satisfaction HCAHPS Grand Composite scores to be > 75th percentile by the end of the waiver. Although we are over 95% compliant with Medication Management documentation, we have only earned a 60% on the composite scores on Communication on medications in HCAHPS. We expect effective communication improvement will increase HCAHPS medication scores by 50% by the end of the waiver.

Domain Valuation:

The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #5 – Emergency Department (1 measure)

Las Colinas Medical Center currently tracks and reports Admit decision time to ED departure for admitted patients for JCAHO and internal quality requirements. The current tracking system is already in place and will be modified or improved as necessary to satisfy the requirement of new reporting domain.

In addition, Las Colinas Medical Center has proposed a quality-based project that will provide improvement of care to all Las Colinas Medical Center patients in multiple areas, supporting the ED throughput, quality and safety

The proposed project to Redesign Patient Experience will focus improvement efforts on critical patients experience targets. Satisfaction and experience with Emergency Room services is essential for effective ED throughput and operations. Effective communication about wait times and letting patients know what to expect on their ED visits can decrease left without being seen patients to improve patient safety. Eliminating waiting areas or starting care with standing orders for nursing before physicians see patients will allow ED physicians to spend time with critical patients to facilitate care and admit decisions in < 1 hour more manageable. Improved communication among doctors, nurses and hospital staff is essential to managing through put to facilitate patients to appropriate admitted beds.

Domain Valuation:
The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Category 4: Population-Focused Measures *Las Colinas Medical Center/020979301*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$9,629	$4,454		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$4,454	$4,764	$5,184
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$4,454	$4,765	$5,184
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			$4,764	$5,184
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Calendar Year Jan 2013- Dec 2013	Calendar Year Jan 2014-Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		Calendar Year Jan 2013- Dec 2013	Calendar Year Jan 2014-Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$4,454	$4,764	$5,184
Domain 5: Emergency Department				
Measurement period for report		Calendar Year Jan 2013- Dec 2013	Calendar Year Jan 2014-Dec 2014	Calendar Year Jan 2015- Dec 2015

Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$4,454	$4,764	$5,184
OPTIONAL Domain 6: Children and Adult Core Measures				
Children Core Measures				
Percentage of Live Births Weighing less than 2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean Rate for Nulliparous Singleton Vertex				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Ambulatory Care: Emergency Department Visits				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Central-Line Associated Bloodstream Infections – Neonatal Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adults Core Measures				
Plan All-Cause Readmission				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Diabetes, Short-term Complications Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
COPD Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				

CHF Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adult Asthma Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective Delivery				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Antenatal Steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Care Transitions				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$9,629	$22,270	$23,821	$25,920

Performing Provider Name: Medical Center of Lewisville

Texas Provider Identifier: 094192402

Medical Center of Lewisville will be reporting all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Medical Center of Lewisville healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Domain #1 – Potentially Preventable Admissions (8 measures)

Medical Center of Lewisville currently tracks and reports 2 of the 8 measurements for public reporting. Measurements that have not yet been addressed are:

- Congestive heart Failure Admission Rate
- Diabetes Admission Rates
- Behavioral Health and Substance Abuse Admission Rate
- Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rate
- Hypertension Admission rate
- Pediatric Asthma

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, Medical Center of Lewisville will expand existing data collecting system and optimize old system for new reporting processes.

In addition, DSRIP projects will provide interventions to Medical Center of Lewisville patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain.

The proposed project to Redesign Patient Experience 094192402.2.1 is intended to implement process improvements to change the patient satisfaction and experience utilizing the hospital. This will impact inpatient and outpatient services. Key areas of experience can influence the risk of admission, including communication, care from nurses and doctors and medication management and discharge process. For example, patients in Emergency rooms need good instructions on their disease and medications and/or follow up care that is necessary. The potential exists for patients to not follow the care prescribed because they don't understand the impact of these instructions as it was not communicated effectively. Better communication

can assist in preventing an health care issue from becoming acute and requiring hospitalization, In particular, how well the staff communicates with patients about medications, and whether key information is provided at discharge can directly impact the risk of admission for patients.

The proposed project to Establish a Patient Navigation (094192402.2.3) program for ED patients will work to find primary care and medical homes for patients who frequently use the ED. Patients with chronic diseases need care to medically management their diseases. Without this care, they are more likely to be hospitalized for exacerbation of their disease or for other acute care that is complicated by their chronic disease. By improving access to primary care services, we believe we will see a decrease in admissions for chronic diseases such as Diabetes, COPD and CHF.

Domain Valuation:
The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #2 – 30 Day Readmissions (7 measures)

Medical Center of Lewisville currently tracks and reports 2 of the 7 measurements for public reporting. Measurements that have not yet been addressed are:

- Diabetes: 30-Day Readmissions
- Behavioral Health & Substance Abuse: 30-Day Readmissions
- Chronic Obstructive Pulmonary Disease (COPD): 30-Day Readmissions
- Stroke: 30- Day Readmissions
- Pediatric Asthma: 30-Day Readmissions

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, Medical Center of Lewisville will expand existing data collecting system and optimize old system for new reporting processes.

In addition, DSRIP projects will provide interventions to Medical Center of Lewisville patients in multiple areas, resulting in improvement of PPRs throughout all measurements in the Reporting Domain.

The proposed project to Redesign Patient Experience (094192402.2.1)is intended to implement process improvements to change the patient satisfaction and experience of hospitalization. Key areas of experience can influence the risk of readmission, including communication, care from nurses and doctors and medication management and discharge process. In particular, how well the staff communicates with patients about medications, and whether key information is provided at discharge can directly impact the risk of readmission for patients.

In addition, the proposed project for Sepsis improvement (094192402.2.2) involves the timely identification/diagnosis of sepsis and evidence based treatment for patients. It is also important for Sepsis patients to be placed on the right medications (right antibiotics, vasopressors, etc.) as a part of evidence based care. To ensure patients know what medications they were on in the hospital and what they must take after discharge, effective medication management is vital for continued care of sepsis and reduced risk for readmissions.

We also expect to see a reduction in readmissions for patients with an initial index admission of Sepsis and those readmitted for Sepsis with initial diagnosis other than Sepsis. Readmissions due to medication management will also be reduced.

Domain Valuation:
The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #3 – Potentially Preventable Complications, PPC (1 measure, but 64 reportable metrics)

Currently, 15 of the sixty four measurements are being tracked and reported in a form of public healthcare statistics. All other measures are tracked and reported internally

Currently, HHSC will make potentially preventable event data to providers. In addition, Medical Center of Lewisville will expand existing data collecting system and optimize old system for new reporting processes.

In addition, DSRIP projects will provide interventions to Medical Center of Lewisville patients in multiple areas, resulting in improvement of PPCs throughout all measurements in the Reporting Domain.

The proposed project to implement an innovative program for Sepsis improvement (094192402.2.2) aims to identify /diagnosis Sepsis sooner and begin evidence based treatment to reduce mortality and complications for septic shock and severe sepsis.
Improved sepsis care reduces complications particularly those common in septic patients such as pulmonary embolism, acute myocardial infarction, venous thrombosis, major liver complications, renal failure with and without Dialysis and encephalopathy. Also, the project will focus on reducing the average length of stay for sepsis patients. Reducing the length of stay of patients diagnosed with sepsis will also impact a reduction in complications. Evidence shows with increased length of stay there is increased risk of preventable complications.

The proposed project to Redesign the Patient Experience (094192402.2.1) will focus on patients satisfaction and experience. Improved patient communication and satisfaction with caregivers has been shown to improve quality and safety of care. Poor communications including nurse and doctor responses to patients has been correlated to increased beds sores, bloodstream infections, catheter-related Infections and leg or lung blood clots. A reduction in preventable complications is expected with a redesigned patient experience.

Domain Valuation:
The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #4 – Patient-Centered Healthcare (2 measures)

Currently, 2 of the two measurements are being tracked and reported.

Patient Satisfaction is surveyed by Gallup for HCAHPS requirements. It is reported internally each week for preliminary results. As required, final results are report to CMS and posted publically. Publicly reported HCAHPS results are based on four consecutive quarters of patient surveys. CMS publishes participating hospitals' HCAHPS results on the Hospital Compare website (www.hospitalcompare.hhs.gov) four times a year, with the oldest quarter of patient surveys rolling off as the most recent quarter rolls on. Additional HCAHPS results can be found on HCAHPS On-Line, (www.hcahpsonline.org).

Medication management is only reported publically as a required element of certain CORE MEASURES reporting. However, it is tracked and reported internally for all inpatients by the quality department as a patient safety and quality of care measurement.

Medical Center of Lewisville will expand existing data collecting system and optimize old system for new reporting processes as necessary.

In addition, Medical Center of Lewisville has proposed several quality-based projects that will provide improvement of care to all Medical Center of Lewisville patients in multiple areas, resulting in improvement patient satisfaction throughout all measurements in the Reporting Domain.

The proposed project to Redesign Patient Experience (094192402.2.1) is aimed at improving the patient satisfaction of the care received (RD-4 1. Patient Satisfaction).The goal to improve patient satisfaction and experience is also important for improved quality and safety of care provided. Studies have linked patient satisfaction with communication with doctor nurses, responsive to patients' needs and cleanliness to patient perceptions of hospital practices and facility infection rates.

Another focus for Redesign Patient Experience is medication management (RD-4 2. Medication management). How well the staff communicates with patients about medicines, and whether key information is provided at discharge is critical to successful medication management and patient safety.

The proposed project for process improvement for Sepsis (094192402.2.2)care involves the timely identification/diagnosis of sepsis and evidence based treatment for patients. Improving processes in this program includes effective communication. The communication between the emergency room, doctors, nurses/ care givers and families for these critically ill patients is vital to the plan of care. Teaching patients and families the cause and symptoms of sepsis is also important for care management . Patient satisfaction is improved with effective communication.

It is also important for Sepsis patients to be placed on the right medications (right antibiotics, vasopressors, etc.) as a part of evidence based care. To ensure patients know what medications they were on in the hospital and what they must take after discharge, effective medication management if vital for continued care of sepsis.

We expected to improve Patient satisfaction HCAHPS Grand Composite scores to be > 75th percentile by the end of the waiver. Although we are over 95% compliant with Medication Management documentation, we have only earned a 59% on the composite scores on Communication on medications in HCAHPS. We expect effective communication improvement will increase HCAHPS medication scores by 50% by the end of the waiver.

Domain Valuation:
The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #5 – Emergency Department (1 measure)

Medical Center of Lewisville currently tracks and reports Admit decision time to ED departure for admitted patients for JCAHO and internal quality requirements. The current tracking system is already in place and will be modified or improved as necessary to satisfy the requirement of new reporting domain.

In addition, several DSRIP projects will provide interventions to patients in multiple areas, resulting in improvement in the Reporting Domain.
The proposed project for Sepsis improvement project (094192402.2.2) involves the timely identification and evidence based treatment of patients. A key component of a Sepsis protocol is the timely identification/diagnosis of septic shock/severe sepsis to admit and begin evidence based treatment.

The proposed project to Establish a Patient Navigation program (094192402.2.3) for ED patients will work to find primary care and medical homes for patients who frequently use the ED. Patients with chronic diseases need care to medically management their diseases instead of using ED too often for episodic care. With a reduction in inappropriate ED visits, hospitals will create capacity to better service those in need of true emergency services and allow for improved emergency care.

Process improvements implemented for sepsis protocols in the ED and decreasing inappropriate visits support the goal of less than 1 hour for ED admit/ departure (decision time) for critical patients.

Domain Valuation:
The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Category 4: Population-Focused Measures *Medical Center of Lewisville/094192402*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$51,563	$23,907		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$23,907	$25,575	$27,799
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$23,907	$25,575	$27,799
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			$25,575	$27,799
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Calendar Year Jan 2013-Dec 2013	Calendar Year Jan 2014- Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		Calendar Year Jan 2013-Dec 2013	Calendar Year Jan 2014- Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$23,907	$25,575	$27,799
Domain 5: Emergency Department				
Measurement period for report		Calendar Year Jan 2013-Dec 2013	Calendar Year Jan 2014- Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2

Domain 5 - Estimated Maximum Incentive Amount		$23,907	$25,575	$27,799
OPTIONAL Domain 6: Children and Adult Core Measures				
Children Core Measures				
Percentage of Live Births Weighing less than 2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean Rate for Nulliparous Singleton Vertex				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Ambulatory Care: Emergency Department Visits				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Central-Line Associated Bloodstream Infections – Neonatal Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adults Core Measures				
Plan All-Cause Readmission				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Diabetes, Short-term Complications Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
COPD Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
CHF Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adult Asthma Admission Rate				

Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective Delivery				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Antenatal Steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Care Transitions				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$51,563	$119,535	$127,875	$138,995

Performing Provider Name: Medical City Dallas

Texas Provider Identifier: 020943901

Medical City Dallas will be reporting all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Medical City Dallas healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3

Domain #1 – Potentially Preventable Admissions (8 measures)

Medical City Dallas currently tracks and reports 2 of the 8 measurements for public reporting. Measurements that have not yet been addressed are:

- Congestive heart Failure Admission Rate
- Diabetes Admission Rates
- Behavioral Health and Substance Abuse Admission Rate
- Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rate
- Hypertension Admission rate
- Pediatric Asthma

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, Medical City Dallas will expand existing data collecting system and optimize old system for new reporting processes.

In addition, DSRIP projects will provide interventions to Medical City Dallas patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain.

The following proposed projects related to Reporting Domains:

- Expanding Telepsychiatry to Emergency Rooms supports access to specialty care. This will allow access to appropriate assessment, treatment and disposition to prevent unnecessary inpatient admission.
- Establish a Primary care Clinic for Pediatrics in North Dallas gives patients access to a medical home. With access to a medical provider and programs such as Illness to

Wellness Program for children with acute and chronic diseases, Healthy Babies and Healthy Kids programs for preventive care such as immunizations we believe admissions can be avoided in particular for chronic disease such as asthma. With appropriate parent education about providing proper care to new born children and proper instruction on how to and when to access services, particularly during a child's first two years we believe admissions can be avoided.

- Expanding the medical home of patients who are medically indigent will allow for more effective care. Patients are assigned to a "home" with a health care team who provides services based on a patient's unique health needs, effectively coordinates the patient's care across inpatient and outpatient settings and proactively provides preventive, primary, routine and chronic care. We believe admissions particularly for chronic diseases such as Congestive Heart Failure, Diabetes, COPD and Hypertension can be avoided with comprehensive primary care.

- Integrating Primary and Behavioral Health care will allow patients to have their psychiatric and medical care addressed at the same site by providers who will coordinate their care. We believe providing primary care in a collaborative manor to patients with behavioral health issues and particularly those patients with existing chronic diseases will prevent admissions.

We expect Behavioral Health and Substance Abuse admissions to be reduced by 20% from DY 2 to DY 5, Behavioral Health and Substance Abuse readmissions will be reduced 10% from DY 2 to DY5, Pediatric Asthma ED Visits will be reduced by 15 % by DY5 and Admissions for chronically ill patients in medical home will be reduced by 25 % from DY 2 to DY 5.

Domain Valuation:

The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #2 – 30 Day Readmissions (7 measures)

Medical City Dallas currently tracks and reports 2 of the 7 measurements for public reporting. Measurements that have not yet been addressed are:

- Diabetes: 30-Day Readmissions
- Behavioral Health & Substance Abuse: 30-Day Readmissions
- Chronic Obstructive Pulmonary Disease (COPD): 30-Day Readmissions
- Stroke: 30- Day Readmissions
- Pediatric Asthma: 30-Day Readmissions

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, Medical City Dallas will expand existing data collecting system and optimize old system for new reporting processes.

In addition, DSRIP projects will provide interventions to patients in multiple areas, resulting in improvement of PPRs throughout all measurements in the Reporting Domain.

The proposed project for Sepsis improvement involves the timely identification/diagnosis of sepsis and evidence based treatment for patients. It is also important for Sepsis patients to be placed on the right medications (right antibiotics, vasopressors, etc.) as a part of evidence based care. To ensure patients know what medications they were on in the hospital and what they must take after discharge, effective medication management is vital for continued care of sepsis and reduced risk for readmissions.

Expanding Telepsychiatry to Emergency Rooms supports access to specialty care. This will allow access to appropriate assessment, treatment and disposition rather than inpatient admission.

Establishing a Primary care Clinic for Pediatrics in North Dallas gives patients access to a medical home. With access to a medical provider, post-discharge care can be coordinated with the provider for improvements in care transitions from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions.

Expanding the medical home of patients who are medically indigent will allow for more effective care. Patients are assigned to a “home” with a health care team who provides services based on a patient’s unique health needs, effectively coordinates the patient’s care across inpatient and outpatient settings and proactively provides preventive, primary, routine and chronic care. We believe re-admissions particularly for chronic diseases such as Congestive Heart Failure, Diabetes, COPD and Hypertension can be avoided with comprehensive primary care follow-up from admission.
Integrating Primary and Behavioral Health care will allow patients to have their psychiatric and medical care addressed at the same site by providers who will coordinate their care. Transitioning care from an inpatient setting to post-discharge can be difficult with lack of

provider availability and behavioral health complexities to address. A setting in which primary and behavioral health are managed provided a more comprehensive continuity of a care to address medications and discharge instructions and can prevent re-admissions with collaborative approach of addressing unique needs of the patients.

We expected Behavior Health and Substance Abuse Re-Admissions to be reduced by 10% by DY 5.

Domain Valuation:
The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #3 – Potentially Preventable Complications, PPC (1 measure, but 64 reportable metrics)

Currently, 15 of the sixty four measurements are being tracked and reported in a form of public healthcare statistics. All other measures are tracked and reported internally

Currently, HHSC will make potentially preventable event data to providers. In addition, Medical City Dallas will expand existing data collecting system and optimize old system for new reporting processes.

In addition, many DSRIP projects will provide interventions to patients in multiple areas, resulting in improvement of PPCs throughout all measurements in the Reporting Domain.
The proposed project to implement an innovative program for Sepsis improvement aims to identify /diagnosis Sepsis sooner and begin evidence based treatment to reduce mortality and complications for septic shock and severe sepsis.
Improved sepsis care reduces complications particularly those common in septic patients such as pulmonary embolism, acute myocardial infarction, venous thrombosis, major liver complications, renal failure with and without Dialysis and encephalopathy. In addition, with active surveillance of inpatients for signs of sepsis, complications such as shock and severe infections in the identified patients can be prevented. The project also will focus on reducing the average length of stay for sepsis patients. Reducing the length of stay of patients diagnosed

with sepsis will also impact a reduction in complications. Evidence shows with increased length of stay there is increased risk of preventable complications.

Expanding a Telemedicine for stroke will allow for greater access to specialty care and rapid triage and management of stroke that can decrease preventable complications. By providing increase access to both the standard of care and cutting –edge therapies in acute stroke, we will be able to improve complication rates of intracerebral hemorrhage (sICH), pneumonia, venous thrombosis, ulcers and DVTe's.
The project also will focus on reducing the average length of stay for stroke patients. Reducing the length of stay of patients will also impact a reduction in complications. Evidence shows with increased length of stay there is increased risk of preventable complications.

Domain Valuation:

The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #4 – Patient-Centered Healthcare (2 measures)

Currently, 2 of the two measurements are being tracked and reported.

Patient Satisfaction is surveyed by Gallup for HCAHPS requirements. It is reported internally each week for preliminary results. As required, final results are report to CMS and posted publically. Publicly reported HCAHPS results are based on four consecutive quarters of patient surveys. CMS publishes participating hospitals' HCAHPS results on the Hospital Compare website (www.hospitalcompare.hhs.gov) four times a year, with the oldest quarter of patient surveys rolling off as the most recent quarter rolls on. Additional HCAHPS results can be found on HCAHPS On-Line, (www.hcahpsonline.org).

Medication management is only reported publically as a required element of certain CORE MEASURES reporting. However, it is tracked and reported internally for all inpatients by the quality department as a patient safety and quality of care measurement.

Medical City Dallas will expand existing data collecting system and optimize old system for new reporting processes as necessary.

In addition, Medical City Dallas has proposed several quality-based projects that will provide improvement of care to all Medical City Dallas patients in multiple areas, resulting in improvement patient satisfaction throughout all measurements in the Reporting Domain.

The proposed project for process improvement for Sepsis care involves the timely identification/diagnosis of sepsis and evidence based treatment for patients. Improving processes in this program includes effective communication. The communication between the emergency room, doctors, nurses/ care givers and families for these critically ill patients is vital to the plan of care. Teaching patients and families the cause and symptoms of sepsis is also important for care management. Patient satisfaction is improved with effective communication.

It is also important for Sepsis patients to be placed on the right medications (right antibiotics, vasopressors, etc.) as a part of evidence based care. To ensure patients know what medications they were on in the hospital and what they must take after discharge, effective medication management if vital for continued care of sepsis.

Expanding Telepsychiatry to Emergency Rooms supports access to specialty care. Patient experience and satisfaction with their doctors and hospital can be improved with physicians having better knowledge of patients' medical and behavioral health treatment. Access to psychiatrist can also assist with appropriate medication and dosage for psychiatric medications while being treated for acute medical conditions. This will improve the information available for better medication management.

Expanding telemedicine for stroke care also supports access to specialty care. Patient experience and satisfaction with their doctors and hospital can be improved with physicians having better knowledge of patients' medical treatment that is required. With improvement in stroke care, there can be less transfers and appropriate, safe and timely treatment for patients presenting with stroke symptoms.

Domain Valuation:

The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Domain #5 – Emergency Department (1 measure)

Domain Description:

Medical City Dallas currently tracks and reports Admit decision time to ED departure for admitted patients for JCAHO and internal quality requirements. The current tracking system is already in place and will be modified or improved as necessary to satisfy the requirement of new reporting domain

In addition, several DSRIP projects will provide interventions to patients in multiple areas, resulting in improvement in the Reporting Domain.

The proposed project for Sepsis improvement involves the timely identification and evidence based treatment of patients. A key component of a Sepsis protocol is the timely identification/diagnosis of septic shock/severe sepsis to admit and begin evidence based treatment. Process improvements implemented for sepsis protocols in the ED support the goal of less than 1 hour for ED admit/ departure (decision time) for critical patients.

Expanding a Telemedicine for stroke will allow for greater access to specialty care and rapid triage and management of stroke. Specialists help emergency room physicians in the decision making process for appropriate treatment for their patients who suffer acute stroke. The program developed best evidence-based protocols in ED and the telestroke goal is to deliver bi-directional consult and start treatment within 1 hour of request promoting a less than 1 hour ED admit time.

Expanding Telepsychiatry to Emergency Rooms supports timely access to specialty care. This will allow access to appropriate assessment, treatment and disposition for patients in the ED. Patients will no longer be "boarded" in ED requiring staff and physician time until disposition can be determined which is typically 24 hours to 3 days. Timely treatment of ED behavioral health patients support the goal of less than 1 hour for ED admit/ departure (decision time) for critical patients by unclogging ED beds and allowing physicians and staff to treat other patients timely.

Domain Valuation:

The total Category 4 value was determined to be at the maximum allowed (10%) per the approved Program Funding and Mechanics Protocol for the Delivery System Incentive Reform Payment pool. Based on the total value of category 4, each domain was valued equally as a proportion of total.

We felt the value of each population focused improvement was equally important to the overall reporting of measurements. The resources needed for tracking, and gather data and reporting were not deemed materially different to warrant significant valuation variances amount the domains or measures.

Category 4: Population-Focused Measures *Medical City Dallas/020943901*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$328,555	$151,570		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$151,570	$162,216	$176,243
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$151,570	$162,215	$176,243
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			$162,215	$176,243
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Calendar Year Jan 2013-Dec 2013	Calendar Year Jan 2014-Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		Calendar Year Jan 2013-Dec 2013	Calendar Year Jan 2014-Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$151,570	$162,215	$176,243
Domain 5: Emergency Department				
Measurement period for report		Calendar Year Jan 2013-Dec 2013	Calendar Year Jan 2014-Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2

Domain 5 - Estimated Maximum Incentive Amount		$151,570	$162,215	$176,243
OPTIONAL Domain 6: Children and Adult Core Measures				
Children Core Measures				
Percentage of Live Births Weighing less than 2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean Rate for Nulliparous Singleton Vertex				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Ambulatory Care: Emergency Department Visits				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Central-Line Associated Bloodstream Infections – Neonatal Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adults Core Measures				
Plan All-Cause Readmission				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Diabetes, Short-term Complications Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
COPD Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
CHF Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				

Adult Asthma Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective Delivery				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Antenatal Steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Care Transitions				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$328,555	$757,850	$811,076	$881,215

Performing Provider Name: Methodist Charlton Medical Center

Texas Provider Identifier: 126679303

Domain #1 – Potentially Preventable Admissions (8 measures)

- **Description** – Methodist Charlton Medical Center will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions (PPAs), which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Methodist Charlton Medical Center expects that its provision of expanded primary care services under its Category 2 projects will reduce the number of PPAs over the life of the Waiver. Patients with chronic diseases may also be aided in being better able to engage in self-management goals and activities of daily living through Methodist Charlton Medical Center's work with other primary care providers.

Valuation Rationale/Justification – The value Methodist Charlton Medical Center placed on this domain is based on the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in RHP 9 will have a beneficial impact on individual patient outcomes and reduce the financial burden of paying for PPAs. Currently, a significant number of hospitalizations can be linked to manageable chronic diseases that Methodist Charlton Medical Center intends to address with its Category 2 projects to expand access to primary care and specialty care.

Domain #2 – 30 Day Readmissions (7 measures)

- **Description** – Methodist Charlton Medical Center will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Methodist Charlton Medical Center expects that its provision of expanded primary care services through local clinics will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR. Expanded access to primary care and specialty care support at local clinics should also have a positive impact on the rate of readmissions to the hospital.

Valuation Rationale/Justification - The value Methodist Charlton Medical Center placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs in RHP Region 9 will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs.

Domain #3 – Potentially Preventable Complications, PPC (1 measure, but 64 reportable metrics)

- **Description** – Methodist Charlton Medical Center will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and Methodist Charlton Medical Center is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Methodist Charlton Medical Center expects that its Category 2 projects to expand access to primary care will reduce the strain on hospital resources (including staff, space, and equipment). With the reduction in avoidable hospital visits, Methodist Charlton Medical Center can redirect its efforts to making the changes and/or improvements necessary to reduce the number of PPCs during the life of the Waiver. The ongoing quality improvement activities which constitute an essential part of many of Methodist Charlton Medical Center' Category 2 and 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout LPDS.

Valuation Rationale/Justification - The value Methodist Charlton Medical Center placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital's patients and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

Domain #4 – Patient-Centered Healthcare (2 measures)

- **Description** – Methodist Charlton Medical Center will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient's willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. Methodist Charlton Medical Center is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital's providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Methodist Charlton Medical Center expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with Methodist Charlton Medical Center's Category 2 projects to enhance interpretation services and culturally competent care, because when patients receive easily-understandable, culturally competent care, they will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).

Valuation Rationale/Justification - The value Methodist Charlton Medical Center placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Methodist Charlton Medical Center and how well Methodist Charlton Medical Center performs its function of promoting medication management. Methodist Charlton Medical Center is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in North Texas is costly to patients' health and to the delivery system, and Methodist Charlton Medical Center believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community.

Domain #5 – Emergency Department (1 measure)

- **Description** – Methodist Charlton Medical Center will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers. The patients may experience poor health outcomes as a result of delays in evaluation and lengthy waits that may lead to

the patient leaving without being seen. Methodist Charlton Medical Center is committed to reducing its ED admitting decision time to ED departure if it is not within the recommended < 1 hour threshold. One cause of extended ED departure times results from an overcrowded ED. Methodist Charlton Medical Center intends to expand access to primary care for patients who currently are unable to access primary care due to their financial situation, which Methodist Charlton Medical Center expects will reduce the number of inappropriate ED visits.

Valuation Rationale/Justification - The value Methodist Charlton Medical Center placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, failure to be seen, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

Category 4: Population-Focused Measures *Methodist Charlton Medical Center/126679303*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$190,946	$88,532		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$88,532	$94,709	$102,945
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$88,532	$94,709	$102,945
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			$94,709	$102,945
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		10/1/2013 – 9/30/14	10/1/2014 – 9/30/2015	10/1/2015 – 9/30/2016
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		10/1/2013 – 9/30/14	10/1/2014 – 9/30/2015	10/1/2015 – 9/30/2016
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$88,532	$94,709	$102,945
Domain 5: Emergency Department				
Measurement period for report		10/1/2013 – 9/30/14	10/1/2014 – 9/30/2015	10/1/2015 – 9/30/2016

Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$88,532	$94,709	$102,945
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measure for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$190,946	$442,660	$473,545	$514,725

Performing Provider Name: Methodist Dallas Medical Center

Texas Provider Identifier: 135032405

Domain #1 – Potentially Preventable Admissions (8 measures)

- **Description** – Methodist Dallas Medical Center will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions (PPAs), which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Methodist Dallas Medical Center expects that its provision of expanded primary care services under its Category 2 projects will reduce the number of PPAs over the life of the Waiver. Patients with chronic diseases may also be aided in being better able to engage in self-management goals and activities of daily living through Methodist Dallas Medical Center's work with other primary care providers.

Valuation Rationale/Justification – The value Methodist Dallas Medical Center placed on this domain is based on the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in RHP 9 will have a beneficial impact on individual patient outcomes and reduce the financial burden of paying for PPAs. Currently, a significant number of hospitalizations can be linked to manageable chronic diseases that Methodist Dallas Medical Center intends to address with its Category 2 projects to expand access to primary care and specialty care.

Domain #2 – 30 Day Readmissions (7 measures)

- **Description** – Methodist Dallas Medical Center will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Methodist Dallas Medical Center expects that its provision of expanded primary care services through local clinics will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR. Expanded

access to primary care and specialty care support at local clinics should also have a positive impact on the rate of readmissions to the hospital.

Valuation Rationale/Justification - The value Methodist Dallas Medical Center placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs in RHP Region 9 will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs.

Domain #3 – Potentially Preventable Complications, PPC (1 measure, but 64 reportable metrics)

- **Description** – Methodist Dallas Medical Center will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and Methodist Dallas Medical Center is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Methodist Dallas Medical Center expects that its Category 2 projects to expand access to primary care will reduce the strain on hospital resources (including staff, space, and equipment). With the reduction in avoidable hospital visits, Methodist Dallas Medical Center can redirect its efforts to making the changes and/or improvements necessary to reduce the number of PPCs during the life of the Waiver. The ongoing quality improvement activities which constitute an essential part of many of Methodist Dallas Medical Center' Category 2 and 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout LPDS.

Valuation Rationale/Justification - The value Methodist Dallas Medical Center placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital's patients and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

Domain #4 – Patient-Centered Healthcare (2 measures)

- **Description** – Methodist Dallas Medical Center will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient's willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. Methodist Dallas Medical Center is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital's providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Methodist Dallas Medical Center expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with Methodist Dallas Medical Center's Category 2 projects to enhance interpretation services and culturally competent care, because when patients receive easily-understandable, culturally competent care, they will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).

Valuation Rationale/Justification - The value Methodist Dallas Medical Center placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Methodist Dallas Medical Center and how well Methodist Dallas Medical Center performs its function of promoting medication management. Methodist Dallas Medical Center is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in North Texas is costly to patients' health and to the delivery system, and Methodist Dallas Medical Center believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community.

Domain #5 – Emergency Department (1 measure)

- **Description** – Methodist Dallas Medical Center will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers. The patients may experience poor health outcomes as a result of delays in evaluation and lengthy waits that may lead to the patient leaving without being seen. Methodist Dallas Medical Center is committed to reducing its ED admitting decision time to ED departure if it is not within the recommended < 1 hour threshold. One cause of extended ED departure times results from an overcrowded ED. Methodist Dallas Medical Center intends to expand access to primary care for patients who currently are unable to access primary care due to their financial situation, which Methodist Dallas Medical Center expects will reduce the number of inappropriate ED visits.

Valuation Rationale/Justification - The value Methodist Dallas Medical Center placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, failure to be seen, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

Category 4: Population-Focused Measures *Methodist Dallas Medical Center/135032405*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$352,077	$162,083		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$162,083	$173,900	$189,841
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$162,083	$173,900	$189,841
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			$173,900	$189,841
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		10/1/2013 – 9/30/14	10/1/2014 – 9/30/2015	10/1/2015 – 9/30/2016
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		10/1/2013 – 9/30/14	10/1/2014 – 9/30/2015	10/1/2015 – 9/30/2016
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$162,083	$173,900	$189,841
Domain 5: Emergency Department				
Measurement period for report		10/1/2013 – 9/30/14	10/1/2014 – 9/30/2015	10/1/2015 – 9/30/2016

Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$162,083	$173,900	$189,841
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaisd and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$352,077	$810,415	$869,499	$949,205

Performing Provider Name: Methodist Richardson Medical Center

Texas Provider Identifier: 209345201

Domain #1 – Potentially Preventable Admissions (8 measures)

- **Description** – Methodist Richardson Medical Center will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions (PPAs), which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Methodist Richardson Medical Center expects that its provision of expanded primary care services under its Category 2 projects will reduce the number of PPAs over the life of the Waiver. Patients with chronic diseases may also be aided in being better able to engage in self-management goals and activities of daily living through Methodist Richardson Medical Center's work with other primary care providers.

Valuation Rationale/Justification – The value Methodist Richardson Medical Center placed on this domain is based on the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in RHP 9 will have a beneficial impact on individual patient outcomes and reduce the financial burden of paying for PPAs. Currently, a significant number of hospitalizations can be linked to manageable chronic diseases that Methodist Richardson Medical Center intends to address with its Category 2 projects to expand access to primary care and specialty care.

Domain #2 – 30 Day Readmissions (7 measures)

- **Description** – Methodist Richardson Medical Center will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Methodist Richardson Medical Center expects that its provision of expanded primary care services through local clinics will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a

PPR. Expanded access to primary care and specialty care support at local clinics should also have a positive impact on the rate of readmissions to the hospital.

Valuation Rationale/Justification - The value Methodist Richardson Medical Center placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs in RHP Region 9 will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs.

Domain #3 – Potentially Preventable Complications, PPC (1 measure, but 64 reportable metrics)

- **Description** – Methodist Richardson Medical Center will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and Methodist Richardson Medical Center is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Methodist Richardson Medical Center expects that its Category 2 projects to expand access to primary care will reduce the strain on hospital resources (including staff, space, and equipment). With the reduction in avoidable hospital visits, Methodist Richardson Medical Center can redirect its efforts to making the changes and/or improvements necessary to reduce the number of PPCs during the life of the Waiver. The ongoing quality improvement activities which constitute an essential part of many of Methodist Richardson Medical Center' Category 2 and 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout LPDS.

Valuation Rationale/Justification - The value Methodist Richardson Medical Center placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital's patients and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

Domain #4 – Patient-Centered Healthcare (2 measures)

- **Description** – Methodist Richardson Medical Center will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient's willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. Methodist Richardson Medical Center is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital's providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Methodist Richardson Medical Center expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with Methodist Richardson Medical Center's Category 2 projects to enhance interpretation services and culturally competent care, because when patients receive easily-understandable, culturally competent care, they will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).

Valuation Rationale/Justification - The value Methodist Richardson Medical Center placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Methodist Richardson Medical Center and how well Methodist Richardson Medical Center performs its function of promoting medication management. Methodist Richardson Medical Center is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in North Texas is costly to patients' health and to the delivery system, and Methodist Richardson Medical Center believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community.

Domain #5 – Emergency Department (1 measure)

- **Description** – Methodist Richardson Medical Center will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers. The patients may experience poor health outcomes as a result of delays in evaluation and lengthy waits that may lead to the patient leaving without being seen. Methodist Richardson Medical Center is committed to reducing its ED admitting decision time to ED departure if it is not within the recommended < 1 hour threshold. One cause of extended ED departure times results from an overcrowded ED. Methodist Richardson Medical Center intends to expand access to primary care for patients who currently are unable to access primary care due to their financial situation, which Methodist Richardson Medical Center expects will reduce the number of inappropriate ED visits.

Valuation Rationale/Justification - The value Methodist Richardson Medical Center placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, failure to be seen, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

Category 4: Population-Focused Measures *Methodist Richardson Medical Center/ 209345201*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$73,914	$34,270		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$34,270	$36,661	$39,849
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$34,270	$36,661	$39,849
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			$36,661	$39,849
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$34,270	$36,661	$39,849
Domain 5: Emergency Department				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$34,270	$36,661	$39,849
OPTIONAL Domain 6: Children and Adult Core Measures				

Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHOP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$73,914	$171,350	$183,305	$199,245

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Domain 1: Potentially Preventable Admissions (8 measures)
Domain Description:

1- Congestive Heart Failure Admission Rate
2- *Diabetes Admission Rate*
3- Behavioral Health and Substance Abuse Admission Rate
4- *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Adults Admission Rate*
5- *Hypertension Admission Rate*
6- Pediatric Asthma – NA
7- Bacterial Pneumonia Immunization
8- Influenza Immunization

Parkland projects that will impact potentially preventable admission rates for chronic conditions such as CHF (1), Diabetes (2), COPD (4) and Hypertension (5) are listed below. Parkland intends to reduce preventable admissions for chronic conditions by increasing access to primary and specialty care, expanding the medical home model and implementing a chronic care model for those patients with specific chronic conditions. Parkland will establish a chronic disease management registry to track and monitor care and assign patients to medical homes/care teams. As a function of chronic disease management and medical home assignment, patients will receive preventive care such as immunizations (7,8), patients on persistent medications will be monitored for use of ACE inhibitors and ARBs and patients with certain conditions such as diabetes will receive recommended care/treatment such as retinal eye exams and foot exams. Parkland projects will have no impact on pediatric asthma (6).

COPD (4). Additional research needs to be done on the COPD patient population. Once the research is complete and as a function of chronic disease management and medical home assignment, patients with COPD will be enrolled in the chronic care model/registry and assigned to medical homes.

Behavioral (3). The 2011 NCQA Medical Home standards require implementation of evidence-based guidelines for "unhealthy behavior, mental health or substance abuse." Patients assigned to medical homes within Parkland's primary care network will receive appropriate care based on their behavioral health needs as well as their medical needs. Treatment plans will be created by the care team, which will include primary care and behavioral health providers. The medical home model provides appropriate care for patients with medical and behavioral needs and should reduce potentially preventable admission rates for this population.

Category 1 Projects
127295703.1.1 (1.1.2) Expand Primary Care Capacity – Grand Prairie Clinic
127295703.1.2 (1.1.2) Expand Existing Primary Care Capacity
127295703.1.3 (1.3.1) Implement Chronic Disease Management Registry
127295703.1.5 (1.9.2) Expand Specialty Care Capacity

127295703.1.6 (1.1.1) Establish Primary Care Clinics – Acute Response Clinic
Category 2 Projects
127295703.2.1 (2.1.1) Enhance/Expand Medical Home Model
127295703.2.4 (2.2.1) Expand Chronic Care Management Model
127295703.2.11 (2.1.1) Enhance/Expand Medical Home Model – Family Medicine

Reporting Cycle: Calendar Year (HHSC data source)

Domain Valuation:

Approach/Methodology

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DSRIP Year (DY) were divided by the number of reporting domains to calculate the value for each domain and DSRIP Year.

Rationale/Justification

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. The rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
Domain Description:

1- *Congestive Heart Failure: 30-Day Readmission Rate*
2- *Diabetes: 30-Day Readmission Rate*
3- *Behavioral Health and Substance Abuse: 30-Day Readmission Rate*
4- *Chronic Obstructive Pulmonary Disease (COPD): 30-Day Readmission Rate*
5- *Stroke: 30-Day Readmission Rate*
6- *Pediatric Asthma: N/A*
7- *All-Cause: 30-Day Readmission Rate*

Parkland category will impact readmission rates (including readmissions for All Cause #7) for the above chronic conditions including CHF (1) and Diabetes (2) through the projects listed below. Parkland intends to reduce preventable readmissions for patients with chronic conditions by increasing access to primary and specialty care, expanding the medical home model and implementing a chronic care model for those patients with specific chronic conditions. Parkland will establish a chronic disease management registry to track and monitor care and assign patients to medical homes/care teams. Care management and care coordination of patients with chronic conditions will reduce unnecessary utilization of services such as the ED and will reduce preventable readmissions. Parkland projects will have little to no effect on stroke readmissions (5) and pediatric asthma (6).

COPD (4). Additional research needs to be done on the COPD patient population. Once the research is complete, patients with COPD will be enrolled in the chronic care model/registry and assigned to medical homes.

Behavioral (3). The 2011 NCQA Medical Home standards require implementation of evidence-based guidelines for unhealthy behavior, mental health or substance abuse. Patients assigned to medical homes within Parkland's primary care network will receive appropriate care based on their behavioral health needs as well as their medical needs. Treatment plans will be created by the care team, which will include primary care and behavioral health providers. The medical home model provides appropriate care for patients with medical and behavioral needs and should reduce potentially preventable readmission rates for this population.

In addition to the above, Parkland will establish a comprehensive care coordination program that includes a patient navigator program and a care transitions program. These programs will provide patient-focused services to assist patients in getting to their next step/level of care (whether to a medical home or post-acute service) which will increase compliance with treatment/recovery protocols. Parkland will review the cost-effectiveness of post-acute alternatives to insure patients have access to post-acute services. Parkland will also implement a comprehensive system-wide Quality and Performance Improvement function that will target

quality indicators such as PPAs/PPRs/PPCs. Projects will be identified and prioritized to provide organizational focus to specific clinical improvements. Such projects will utilize performance improvement methodologies such as LEAN to make necessary improvements to the care process/delivery system. Parkland also intends to expand the Outpatient Parenteral Antimicrobial Therapy Program for patients to provide self-care at home with a PICC line.

Category 1 Projects
127295703.1.1 (1.1.2) Expand Primary Care Capacity – Grand Prairie Clinic
127295703.1.2 (1.1.2) Expand Existing Primary Care Capacity
127295703.1.3 (1.3.1) Implement Chronic Disease Management Directory
127295703.1.4 (1.10.4) Enhance Performance Improvement and Reporting Capacity
127295703.1.5 (1.9.2) Expand Specialty Care Capacity
127295703.1.6 (1.1.1) Establish Primary Care Clinics - Acute Response Clinic
Category 2 Projects
127295703.2.1 (2.1.1) Enhance/Expand Medical Home Model
127295703.2.4 (2.2.1) Expand Chronic Care Management Model
127295703.2.7 (2.9.1) Enhance Patient Navigation Program
127295703.2.9 (2.12.1) Implement/Expand Care Transitions Program
127295703.2.11 (2.1.1) Enhance/Expand Medical Home Model – Family Medicine
127295703.2.12 (2.8.4) Apply Process Improvement Methodologies to Improve Quality/Efficiency – OPAT Program
Category 3 Related Outcomes
127295703.3.9 (IT-3.3) Diabetes 30-Day Readmission Rate
127295703.3.24 (IT-3.3) Diabetes 30-Day Readmission Rate
127295703.3.31 (IT-3.3) Diabetes 30-Day Readmission Rate
127295703.3.35 (IT-3.3) Diabetes 30-Day Readmission Rate
127295703.3.11 (IT-3.5) AMI 30-Day Readmission Rate
127295703.3.36 (IT-3.5) AMI 30-Day Readmission Rate
127295703.3.10 (IT-3.1) All Cause 30-Day Readmission Rate
127295703.3.30 (IT-3.1) All Cause 30-Day Readmission Rate
127295703.3.34 (IT-3.1) All Cause 30-Day Readmission Rate
127295703.3.38 (IT-3.1) All Cause 30-Day Readmission Rate
127295703.3.43 (IT-3.12) Other – All Cause Readmission Rate for patients enrolled in OPAT program

Domain Valuation:

Approach/Methodology

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DSRIP Year (DY) were divided by the number of reporting domains to calculate the value for each domain and DSRIP Year.

Rationale/Justification

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. The rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Domain 3: Potentially Preventable Complications (64 measures)
Domain Description:

Parkland's will improve potentially preventable complication rates through two submitted projects – one by enhancing performance improvement and reporting capacity across the health system and the second by applying process improvement methodologies to improve quality and efficiency to improve Sepsis, CLABSI, SSI, and CAUTI rates. Improving the reporting capacity function for process improvement will allow teams to easily identify areas for improvement, develop targeted initiatives, utilize evidence-based best practice methodologies such as LEAN to make improvements and then monitor progress toward improvement. Projects and related outcomes specific to improvements in potentially preventable complication rates are listed below.

Category 1 Projects
127295703.1.4 (1.10.4) Enhance Performance Improvement and Reporting Capacity
Category 2 Projects
127295703.2.6 (2.8.11) Apply Process Improvement Methodology to Improve Quality/Efficiency
Category 3 Related Outcomes
127295703.3.12 (IT-4.2) Central Line-Associated Bloodstream Infection (CLABSI) Rate
127295703.3.27 (IT-4.2) Central Line-Associated Bloodstream Infection (CLABSI) Rate
127295703.3.28 (IT-4.3) Catheter-Associated Urinary Tract Infection (CAUTI) Rate
127295703.3.29 (IT-4.4) Surgical Site Infection (SSI) Rate
127295703.3.44 (IT-4.8) Sepsis Mortality

Reporting Cycle: Calendar Year (HHSC data source)

Domain Valuation:

Approach/Methodology
All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DSRIP Year (DY) were divided by the number of reporting domains to calculate the value for each domain and DSRIP Year.

Rationale/Justification
All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. The rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Domain 4: Patient-Centered Healthcare (2 measures)
Domain Description:

1- Patient Satisfaction
2- *Medication Management*

Patient Satisfaction is surveyed by Press Ganey for HCAHPS requirements. It is reported internally and as required, final results are reported to CMS and posted publically. CMS publishes participating hospitals' HCAHPS results on the Hospital Compare website (www.hospitalcompare.hhs.gov) four times a year, with the oldest quarter of patient surveys rolling off as the most recent quarter rolls on. Additional HCAHPS results can be found on HCAHPS On-Line, (www.hcahpsonline.org).

Parkland's proposed project to "Improve Patient Experience" focuses on improving patient satisfaction. To meet this goal and support institution-wide enhancement of customer service delivery, restructuring and centralization of customer service is required. A Service Excellence Manager position will be established whose purview will include responsibilities for coordinating hospital-wide performance improvement initiatives and unit-level service excellence consulting. This role is a well-established industry "Best Practice" model for customer service enhancement and ultimately the improvement of patient satisfaction scores on standardized surveys.

Another project to improve patient satisfaction is the enhancement of interpretation services for Parkland patients whose primary language is Spanish (approximately 40% of Parkland's patients). Improved communication is linked to improved patient satisfaction and is a key objective for Parkland.

Category 1-2 Projects
127295703.1.7 (1.4.7) Enhance Interpretation Services
127295703.2.10 (2.4.3) Increase Patient Satisfaction
Category 3 Related Outcomes
127295703.3.37 (IT-6.1) Percent Improvement over baseline for patient satisfaction scores
127295703.3.45 (IT-6.1) Percent improvement over baseline for patient satisfaction scores

Medication management is only reported publically as a required element of certain CORE MEASURES reporting. Through the Quality and Performance Improvement Department, Parkland intends to expand data collection for the health system in order to improve reporting capabilities and meet reporting requirements.

Reporting Cycle: Parkland's fiscal year (October 1-September 30)

Domain Valuation:

Approach/Methodology

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DSRIP Year (DY) were divided by the number of reporting domains to calculate the value for each domain and DSRIP Year.

Rationale/Justification

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. The rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Domain 5: Emergency Department (1 measure)
Domain Description:

The project that will improve throughput in Parkland's Emergency Department is listed below. The implementation of these projects will improve throughput in the emergency department through care teams that will be charged with improvements in transferring and discharging patients as well as patient hand offs. The improved flow of patients through the inpatient setting will positively impact the time from "decision to admit to transfer" of patients from the emergency department to the inpatient setting.

Category 1 Projects
127295703.1.1 (1.1.2) Expand existing primary care capacity – Grand Prairie
127295703.1.2 (1.1.2) Expand existing primary care capacity
127295703.1.3 (1.3.1) Implement chronic care registry
127295703.1.5 (1.9.2) Expand specialty care access
127295703.1.6 (1.1.1) Establish primary care clinics – Acute Response
Category 2 Projects
127295703.2.1 (2.1.1) Enhance/expand medical home model - COPC
127295703.2.4 (2.2.1) Expand chronic care model
127295703.2.7 (2.9.1) Enhance Patient Navigation Program
127295703.2.8 (2.10.1) Implement a palliative care program
127295703.2.11 (2.1.1) Enhance/expand medical home model - Family Medicine
127295703.2.12 (2.8.4) Apply Process Improvement methodology to improve quality/ efficiency – OPAT Program
Category 3 Projects
127295703.3.14 (IT-9.2) ED Appropriate Utilization
127295703.3.32 (IT-9.2) ED Appropriate Utilization
127295703.3.33 (IT-13.3) Palliative Care: Proportion of patients w/ one or more ED visits in the last 30 days of life

Reporting Cycle: Parkland's fiscal year (October 1-September 30)

Domain Valuation:

Approach/Methodology
All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DSRIP Year (DY) were divided by the number of reporting domains to calculate the value for each domain and DSRIP Year.

Rationale/Justification
All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. The rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Performing Provider Name/TPI: Parkland Health & Hospital System/127295703

Domain 6: Optional Domain
Domain Description:

At a minimum, providers participating in RD-6 must complete the following measures or provide explanation as to why they cannot be reported.

Initial Core Set of Health Care Measures for Children in Medicaid and CHIP

- Percentage of Live Births Weighing less than 2,500 grams
- Cesarean Rate for Nulliparous Singleton Vertex
- Ambulatory Care: Emergency Department Visits
- Pediatric Central-Line associated Bloodstream Infections—Neonatal Intensive Care Unit and Pediatric Intensive Care Unit

Parkland will not report the following measures for Children:

- Ambulatory Care: ED visits - Children go to Children's Medical Center for ED services
- Pediatric Central Line-Associated Bloodstream Infections – Parkland does measure BSI in the NNICU; however Parkland does not have a Pediatric ICU (Children are sent to Children's Medical Center)

Initial Core Set of Health Care Measures for Medicaid-Eligible Adults

- Plan All-Cause Readmission
- Diabetes, Short-term Complications Admission Rate
- COPD Admission Rate
- CHF Admission Rate
- Adult Asthma Admission Rate
- Elective Delivery
- Antenatal Steroids
- Care Transitions

Parkland intends to report as required the above measures for the adult population. Several of the above measures including admission and readmission rates have been addressed in other Category 4 domains. The Diabetes, COPD, CHF and Adult Asthma Admission Rates will be addressed through the chronic care projects (implement registry/model).

The measures not addressed in Parkland's submitted projects include:

- Adult Asthma Admission Rate
- Elective Delivery
- Antenatal Steroids

Category 1 Projects
127295703.1.1 (1.1.2) Expand existing primary care capacity – Grand Prairie
127295703.1.2 (1.1.2) Expand existing primary care capacity
127295703.1.3 (1.3.1) Implement chronic care registry
127295703.1.5 (1.9.2) Expand specialty care access
127295703.1.6 (1.1.1) Establish primary care clinics – Acute Response
Category 2 Projects
127295703.2.1 (2.1.1) Enhance/expand medical home model
127295703.2.4 (2.2.1) Expand chronic care model – COPC
127295703.2.11 (2.1.1) Enhance/expand medical home model – Family Medicine
Category 3 Projects
127295703.3.1 (IT-1.2) Annual Monitoring of persistent medications: A CE inhibitors or ARBS
127295703.3.4 (IT-1.2) Annual Monitoring of persistent medications: ACE inhibitors or ARBS
127295703.3.7 (IT-1.2) Annual Monitoring of persistent medications: ACE inhibitors or ARBS
127295703.3.15 (IT-1.2) Annual Monitoring of persistent medications: ACE inhibitors or ARBS
127295703.3.22 (IT-1.2) Annual Monitoring of persistent medications: ACE inhibitors or ARBS
127295703.3.2 (IT-1.12) Diabetes Care: Retinal Eye Exam
127295703.3.5 (IT-1.12) Diabetes Care: Retinal Eye Exam
127295703.3.8 (IT-1.12) Diabetes Care: Retinal Eye Exam
127295703.3.16 (IT-1.12) Diabetes Care: Retinal Eye Exam
127295703.3.23 (IT-1.12) Diabetes Care: Retinal Eye Exam
127295703.3.41 (IT-1.12) Diabetes Care: Retinal Eye Exam
127295703.3.42 (IT-1.12) Diabetes Care: Foot Exam

Reporting Cycle: Parkland's fiscal year (October 1-September 30)

Domain Valuation:

Approach/Methodology

All Region 9 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DSRIP Year (DY) were divided by the number of reporting domains to calculate the value for each domain and DSRIP Year.

Rationale/Justification

All of the required reporting domains are pertinent in transforming the healthcare of RHP 9. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. The rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Category 4: Population-Focused Measures *Parkland Health & Hospital System – TPI: 127295703*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$6,632,161	$3,843,770		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$3,843,770	$4,111,940	$4,469,500
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$3,843,770	$4,111,940	$4,469,500
Domain 3: Potentially Preventable Complications (PPCs) - Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$4,111,940	$4,469,500
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2015	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/1/2015	1: 10/1/2015-3/1/2016	1: 10/1/2016-3/1/2017
Medication Management				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Domain 4 - Estimated Maximum Incentive Amount		$3,843,770	$4,111,940	$4,469,500
Domain 5: Emergency Department				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Domain 5 - Estimated Maximum Incentive Amount		$3,843,770	$4,111,940	$4,469,500

Category 4: Population-Focused Measures *Parkland Health & Hospital System – TPI: 127295703*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid/CHIP (24)				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26)				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Domain 6 - Estimated Maximum Incentive Amount		$3,843,770	$4,111,940	$4,469,500
Grand Total Payments Across Category 4	**$6,632,161**	**$23,062,620**	**$24,671,640**	**$26,817,000**

Planned Reporting Period: 1 (October 1 – March 31)
2 (April 1 – September 30)

Performing Provider Name: Doctors Hospital at White Rock Lake

Performing Provider TPI: 094194002

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Doctors Hospital at White Rock Lake will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions (PPAs), which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Doctors Hospital at White Rock Lake expects that its provision of expanded primary care services under its Category 2 projects will reduce the number of PPAs over the life of the Waiver. Patients with chronic diseases may also be aided in being better able to engage in self-management goals and activities of daily living through Doctors Hospital at White Rock Lake's work with other primary care providers.
- **Valuation Rationale/Justification** – The value Doctors Hospital at White Rock Lake placed on this domain is based on the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in RHP 9 will have a beneficial impact on individual patient outcomes and reduce the financial burden of paying for PPAs. Currently, a significant number of hospitalizations can be linked to manageable chronic diseases that Doctors Hospital at White Rock Lake intends to address with its Category 2 projects to expand access to primary care and specialty care. Doctors Hospital at White Rock Lake values this reporting domain at $105,746 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Doctors Hospital at White Rock Lake will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Doctors Hospital at White Rock Lake expects that its provision of expanded primary care services through local clinics will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR. Expanded

access to primary care and specialty care support at local clinics should also have a positive impact on the rate of readmissions to the hospital.

- **Valuation Rationale/Justification** - The value Doctors Hospital at White Rock Lake placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs in RHP Region 9 will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Doctors Hospital at White Rock Lake values this reporting domain at $105,746 over Demonstration Years 3-5.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Doctors Hospital at White Rock Lake will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and Doctors Hospital at White Rock Lake is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Doctors Hospital at White Rock Lake expects that its Category 2 projects to expand access to primary care will reduce the strain on hospital resources (including staff, space, and equipment). With the reduction in avoidable hospital visits, Doctors Hospital at White Rock Lake can redirect its efforts to making the changes and/or improvements necessary to reduce the number of PPCs during the life of the Waiver. The ongoing quality improvement activities which constitute an essential part of many of Doctors Hospital at White Rock Lake' Category 2 and 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout LPDS.
- **Valuation Rationale/Justification** - The value Doctors Hospital at White Rock Lake placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital's patients and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our

starting point and tracking our improvement is essential to making progress. Doctors Hospital at White Rock Lake values this reporting domain at $78,331 over Demonstration Years 4-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Doctors Hospital at White Rock Lake will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient's willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. Doctors Hospital at White Rock Lake is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital's providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Doctors Hospital at White Rock Lake expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with Doctors Hospital at White Rock Lake's Category 2 projects to enhance interpretation services and culturally competent care, because when patients receive easily-understandable, culturally competent care, they will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).

- **Valuation Rationale/Justification** - The value Doctors Hospital at White Rock Lake placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Doctors Hospital at White Rock Lake and how well Doctors Hospital at White Rock Lake performs its function of promoting medication management. Doctors Hospital at White Rock Lake is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in North Texas is costly to patients' health and to the delivery system, and Doctors Hospital at White Rock Lake believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community. Doctors Hospital at White Rock Lake values this reporting domain at $105,744 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description** – Doctors Hospital at White Rock Lake will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers. The patients may experience poor health outcomes as a result of delays in evaluation and lengthy waits that may lead to the patient leaving without being seen. Doctors Hospital at White Rock Lake is committed to reducing its ED admitting decision time to ED departure if it is not within the recommended < 1 hour threshold. One cause of extended ED departure times results from an overcrowded ED. Doctors Hospital at White Rock Lake intends to expand access to primary care for patients who currently are unable to access primary care due to their financial situation, which Doctors Hospital at White Rock Lake expects will reduce the number of inappropriate ED visits.
- **Valuation Rationale/Justification** - The value Doctors Hospital at White Rock Lake placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, failure to be seen, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Doctors Hospital at White Rock Lake values this reporting domain at $105,743 over Demonstration Years 3-5.

Domain 6: Optional Domain: Initial Core Set of Health Care Quality Measures (13 measures)

- **Description** - Doctors Hospital at White Rock Lake will report on CMS' Initial Core Set of Measures for Adults and Children in Medicaid/CHIP. These measures are important because the overarching goal of delivery system reform is to improve the quality of care provided to members of the community who are often underserved, including indigent children and adults. Doctors Hospital at White Rock Lake is committed to providing quality care to all patients, regardless of ability to pay. Accordingly, Doctors Hospital at White Rock Lake has developed and plans to implement Category 2 and 3 projects which will serve the common need of the Dallas community's diverse patient populations for quality and effective care through more effective care transitions and partnership with the Mission East Dallas medical home. More specifically, the tracking and reporting of this domain's measures for children will enable Doctors Hospital at White Rock Lake to perform more effectively its core mission of providing health care to children in the Dallas community.

- **Valuation Rationale/Justification** – The value Doctors Hospital at White Rock Lake placed on this domain is based upon the value the hospital attributes to providing quality care to patients and maintaining a level of consistency in its provision of care. Medicaid and CHIP participants make up a large portion of the consumers of healthcare, and therefore the quality of care provided to this population is indicative of systemic practices. Understanding our starting point and tracking our improvement is essential to making progress. Doctors Hospital at White Rock Lake values this reporting domain at $58,747 over Demonstration Years 3-5.

Category 4: Population-Focused Measures Doctors Hospital at White Rock Lake – TPI: 094194002				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$40,737	$27,415		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$27,415	$31,072	$47,259
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$27,415	$31,072	$47,259
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$31,072	$47,259
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$27,415	$31,071	$47,258
Domain 5: Emergency Department				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive		$27,414	$31,071	$47,258

Amount				
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		~~1~~2	~~1~~2	~~1~~2
Domain 6 - Estimated Maximum Incentive Amount		$15,230	$17,262	$26,255
Grand Total Payments Across Category 4	$40,737	$152,304	$172,620	$262,548

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Reporting Domain #1 – Potentially Preventable Admissions

Performing Provider Name/TPI: Texas Health Dallas (THD)/020908201
Unique RHP identification number: 020908201.4.2

Domain Description:
Currently, all RD-1 measurements are being tracked at reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Dallas (THD) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

Successful Category 1 interventions will lead to health care improvements throughout the waiver period. Implementation of the Continuing Care Clinic (020908201.1.1) will facilitate the reduction of emergency department use and positively impact all-cause admission rate for patients seeking medical care in the Texas Health network.

Category 2 project implementations such as Faith Community Nursing/Health Workers (020908201.2.2) and Healing Hands Ministries (020908201.2.3) will also reduce admission rates for individuals who do not have a place of care other than the emergency department.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and Category 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPA rate.

THD will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain #2 – Potentially Preventable Readmissions

Performing Provider Name/TPI: Texas Health Dallas (THD)/020908201
Unique RHP identification number: 020908201.4.3

Domain Description:
Currently, all RD-2 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THD will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

Successful Category 1 interventions will lead to health care improvements throughout the waiver period. Implementation of the Continuing Care Clinic (020908201.1.1) will facilitate the reduction of emergency department use and positively impact preventable readmission rate for patients seeking medical care in the Texas Health network.

Category 2 project implementations such as Faith Community Nursing/Health Workers (020908201.2.2) and Healing Hands Ministries (020908201.2.3) will also reduce readmissions rates for individuals who do not have a place of care other than the emergency department.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and Category 2 interventions will feed back into Category 4 reporting measures and reduce the overall PPR rate.

THD will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain #3 – Potentially Preventable Complications

Performing Provider Name/TPI: Texas Health Dallas (THD)/020908201
Unique RHP identification number: 020908201.4.4

Domain Description:
Currently, all RD-3 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THD will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THD does not have a project that specifically impacts this reporting domain.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and Category 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPC rate.

THD will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Domain #4 – Patient Centered Healthcare

Performing Provider Name/TPI: Texas Health Dallas (THD)/020908201
Unique RHP identification number: 020908201.4.5

Domain Description:

Currently, all RD-4 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THAM will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THD does not have a project that specifically impacts this reporting domain.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and Category 2 interventions will feed back into Category 4 reporting measures and improve overall patient satisfaction scores.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain #5 – Emergency Department

Performing Provider Name/TPI: Texas Health Dallas (THD)/020908201
Unique RHP identification number: 020908201.4.6

Domain Description:

Currently, all RD-5 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THD will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

Since this particular measure reports on the decision time to transfer an emergency patient to another facility and not the actual transport time, (decision to make the first call form arrival in transferring ED until call initiated) it is advisable that THR work closely with our Care Connect reporting to determine if additional data fields need to be build and collected so a report can be created to meet this NQF 0497 measure. During our preliminary review, it appears that we may be able to utilize a MU report that does capture NQF 0497 for all THR entities participating in MU. In addition, a clear time frame in which the reporting period should encompass needs to be stated clearly.

We expect the Continuing Care Clinic project (020908201.1.1) and the Healing Hands Ministries project (020908201.2.3) to have a positive impact on this domain by helping to navigate patients to appropriate health care resources to assist those with chronic health care needs in receiving ongoing care.

THD will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Option Domain #6 – Children and Adult Core Measures

Performing Provider Name/TPI: Texas Health Dallas (THD)/020908201
Unique RHP identification number: 020908201.4.7

Domain Description:
The child core measure is a domain that THR doesn't have an enough volume to reliably report or for the measurement to be stable and a domain that would not be statistically significant. THR does not meet the minimum volume requirements for publication of these measures by CMS.

Domain Valuation:
THR will not report on RD-6 and, as such, no value has been assigned to this domain.

Category 4: Population-Focused Measures *Texas Health Presbyterian Hospital Dallas/020908201*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$279,885	$163,266		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$163,266	$174,928	$174,928
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$163,266	$174,928	$174,928
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$174,928	$174,928
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report				
Planned Reporting Period: 1 or 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		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$163,266	$174,928	$174,928
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		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$163,266	$174,928	$174,928
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 Amount		~~$163,266~~	~~$174,928~~	~~$174,928~~
Grand Total Payments Across Category 4	$279,885	$816,330	$874,640	$874,640

Repeat table for every hospital reporting Category 4 measures

Reporting Domain #1 – Potentially Preventable Admissions

Performing Provider/TPI: Texas Health Presbyterian Hospital Denton/020967801
Unique RHP identification number: 029067801.4.1

Domain Description:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Presbyterian Denton (THDN) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THDN is not participating in Category 1 interventions.

Successful Category 2 interventions will lead to health care improvements throughout the waiver period. Implementation of a patient care navigation program (020967801.2.1) will facilitate patient navigation and positively impact all-cause admission rate for patients seeking medical care in the Texas Health network. Expanding diabetes specialty care and patient education in primary care settings (130614405.2.1) will reduce diabetes admission rate. Establishing a heart failure clinic (130614405.2.2) will provide additional post-acute care for heart failure patients. Interventions mentioned above will significantly improve all-cause PPA starting in DY4.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPA rate.

THDN will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain #2 – Potentially Preventable Readmissions

Performing Provider/TPI: Texas Health Presbyterian Hospital Denton/020967801
Unique RHP identification number: 029067801.4.2

Domain Description:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Presbyterian Denton (THDN) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THDN is not participating in Category 1 interventions.

Successful Category 2 interventions will lead to health care improvements throughout the waiver period. The Establish/Expand a Patient Care Navigation Program (020967801.2.1) will reduce preventable readmissions by navigating patients to appropriate resources after discharge from the hospital. The Chronic Care Management Model (020967801.2.2) will reduce readmissions through management of chronic diseases especially diabetes.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPR rate.

THDN will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Domain #3 – Potentially Preventable Complications

Performing Provider Name/TPI: Texas Health Presbyterian Denton Hospital/020967801
Unique RHP identification number: 029067801.4.3

Description:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Presbyterian Denton (THDN) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THDN is not participating in Category 1 interventions.

Category 3 outcome and Category 4 reporting measure reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPC rate.

THDN will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY4.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Domain #4 – Patient Centered Healthcare

Performing Provider Name/TPI: Texas Health Presbyterian Denton Hospital/020967801
Unique RHP identification number: 020967801.4.4

Description:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Presbyterian Denton (THDN) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THDN is not participating in Category 1 interventions or Category 2 interventions that will directly impact this reporting domain.

Patient satisfaction Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. THDN will begin to report on all required measurements annually starting in DY3.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Domain #5 – Emergency Department

Performing Provider Name/TPI: Texas Health Presbyterian Denton Hospital/020967801
Unique RHP identifier: 020967801.4.5

Description:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Presbyterian Denton (THDN) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THDN is not participating in Category 1 interventions.

Since this particular measure reports on the decision time to transfer an emergency patient to another facility and not the actual transport time, (decision to make the first call form arrival in transferring ED until call initiated) it is advisable that THR work closely with our Care Connect reporting to determine if additional data fields need to be build and collected so a report can be created to meet this NQF 0497 measure. During our preliminary review, it appears that we may be able to utilize a MU report that does capture NQF 0497 for all THR entities participating in

MU. In addition, a clear time frame in which the reporting period should encompass needs to be stated clearly.

THDN will begin to report on all required measurements annually starting in DY3.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Option Domain #6 – Initial Core Set of Health Care Quality Measures

Performing Provider Name/TPI: Texas Health Presbyterian Denton Hospital/020967801
Unique RHP identifier: 020967801.4.6

Description:
The child core measure is a domain that THR doesn't have an enough volume to reliably report or for the measurement to be stable and a domain that would not be statistically significant. THR does not meet the minimum volume requirements for publication of these measures by CMS.

Valuation: THR will not report on RD-6 and as such no value has been assigned to this domain.

Category 4: Population-Focused Measures *Texas Health Presbyterian Denton Hospital/ 020967801.2.2*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$50,356	$29,374		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$29,374	$31,472	$31,472
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$29,374	$31,472	$31,472
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$31,472	$31,472
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		1	1	1
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		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$29,374	$31,472	$31,472
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-	10/1/2014-

			9/30/2014	9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$29,374	$31,472	$31,472
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 Amount		~~$29,374~~	~~$31,472~~	~~$31,472~~
Grand Total Payments Across Category 4	$50,356	$176,245	$188,834	$188,834

Repeat table for every hospital reporting Category 4 measures

Domain #1 – Potentially Preventable Admissions

Performing Provider/TPI: Texas Health Presbyterian Hospital Kaufman/09410302
Unique RHP identification number: 094140302.4.1

Domain Description:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Presbyterian Kaufman (THK) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THK is not participating in Category 1 interventions.

Successful Category 2 interventions will lead to health care improvements throughout the waiver period. Implementation of a patient care navigation program (020967801.2.1) will facilitate patient navigation and positively impact all-cause admission rate for patients seeking medical care in the Texas Health network. Expanding diabetes specialty care and patient education in primary care settings (09410302.2.1) will reduce diabetes admission rate. Establishing a heart failure clinic (09410302.2.2) will provide additional post-acute care for heart failure patients. Interventions mentioned above will significantly improve all-cause PPA starting in DY4.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPA rate.

THDN will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Domain #2 – Potentially Preventable Readmissions

Performing Provider/TPI: Texas Health Presbyterian Hospital Kaufman/09410302
Unique RHP identification number: 094140302.4.2

Description:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Presbyterian Kaufman (THK) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THK is not participating in Category 1 interventions.

Successful Category 2 interventions will lead to health care improvements throughout the waiver period. The Establish/Expand a Patient Care Navigation Program (09410302.2.1) will reduce preventable readmissions by navigating patients to appropriate resources after discharge from the hospital. The Chronic Care Management Model (09410302.2.2) will reduce readmissions through management of chronic diseases especially diabetes.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPR rate.

THK will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Domain #3 – Potentially Preventable Complications, PPC

Performing Provider/TPI: Texas Health Presbyterian Hospital Kaufman/09410302
Unique RHP identification number: 094140302.4.3

Description:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Presbyterian Kaufman (THK) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THDN is not participating in Category 1 interventions.

Category 3 outcome and Category 4 reporting measure reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPC rate.

THK will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY4.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Domain #4 – Patient Centered Healthcare

Performing Provider/TPI: Texas Health Presbyterian Hospital Kaufman/09410302
Unique RHP identification number: 09410302.4.4

Domain Description:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Presbyterian Kaufman (THK) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THK is not participating in Category 1 interventions or Category 2 interventions that will directly impact this reporting domain.

Patient satisfaction Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. THK will begin to report on all required measurements annually starting in DY3.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Domain #5 – Emergency Department

Performing Provider/TPI: Texas Health Presbyterian Hospital Kaufman/09410302
Unique RHP identification number: 09410302.4.5

Description:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Presbyterian Kaufman (THK) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THDN is not participating in Category 1 interventions.

Since this particular measure reports on the decision time to transfer an emergency patient to another facility and not the actual transport time, (decision to make the first call form arrival in transferring ED until call initiated) it is advisable that THR work closely with our Care Connect reporting to determine if additional data fields need to be build and collected so a report can be created to meet this NQF 0497 measure. During our preliminary review, it appears that we may be able to utilize a MU report that does capture NQF 0497 for all THR entities participating in

MU. In addition, a clear time frame in which the reporting period should encompass needs to be stated clearly. There is no DSRIP project associated with this reporting domain and, therefore, no measureable impact is expected for this domain related to the intervention.

THK will begin to report on all required measurements annually starting in DY3.

Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Optional Reporting Domain #6 – Initial Core Set of Health Care Quality Measures

Performing Provider/TPI: Texas Health Presbyterian Hospital Kaufman/09410302
Unique RHP identification number: 09410302.4.6

Domain Description:
The child core measure is a domain that THR doesn't have an enough volume to reliably report or for the measurement to be stable and a domain that would not be statistically significant. THR does not meet the minimum volume requirements for publication of these measures by CMS.

Domain Valuation:
THR will not report on RD-6 and as such no value has been assigned to this domain.

Category 4: Population-Focused Measures *Texas Health Presbyterian Hospital Kaufman/094140302*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$36,320	$21,187		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$21,187	$22,700	$22,700
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$21,187	$22,700	$22,700
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$22,700	$22,700
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		1	1	1
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		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$21,187	$22,700	$22,700
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-	10/1/2014-

			9/30/2014	9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$21,187	$22,700	$22,700
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 Amount		~~$21,187~~	~~$22,700~~	~~$22,700~~
Grand Total Payments Across Category 4	$36,320	$105,934	$113,501	$113,501

Performing Provider: UT Southwestern University Hospitals/175287501

Domain Descriptions:

RD-1. Potentially Preventable Admissions – This Reporting Domain will be affected by all of the following projects

1. 126686802.1.1 – Newly established primary care clinic
2. 126686802.1.2 – Expanding existing primary care network
3. 126686802.1.3 – Implementing a Quality Incentive Program for PCP Network
4. 126686802.1.4 – Introduce a Telemedicine/Telehealth system
5. 126686802.1.5 – Newly established specialty care clinic
6. 126686802.1.6 – Develop population management infrastructure
7. 126686802.1.7 – CME Program expansion for community PCPs
8. 126686802.1.8 – Family Medicine Residency training programs
9. 126686802.1.9 – PA program expansion
10. 126686802.1.10 – Training Community Workers
11. 126686802.1.11 – Urgent Care Service for Cancer Patients
12. 126686802.1.12 – Quality Improvement Center
13. 126686802.2.1 – Expanding Medical Home in PCP Network
14. 126686802.2.2 – Expand Quality Improvement Training
15. 126686802.2.4 – Implement Care Coordination with PCP network
16. 126686802.2.5 – Implement Care Transitions with PCP network
17. 126686802.2.6 – Conduct Medication Management
18. 175287501.1.1 – Transplant Program
19. 175287501.2.1 – Implement ED Navigator Program
20. 175287501.2.2 – Implement Palliative Care Program
21. 175287501.2.3 – Transitional Care Services for Cancer Inpatients

Each of these projects will contribute to reducing potentially preventable admissions. Projects 1-6 provide greater access to ambulatory care and additional tools for Primary Care Providers to help patients manage their health with going to the ED or into the hospital. Projects 7-8 involve education providers to use more health care and population management tools to help patients stay healthier. Project 11 and 19 are particularly important in helping cancer patients urgent care support at their ambulatory clinic rather than resorting to an ED visit when complications arise. In its first month of operation, this project document over 40 prevented admissions. Project 19 works with patients when they arrive at the ED to get quicker attention and/or referral to more appropriate settings. Projects 15 and 16 help patient get the next step of care that is too often missed, which can lead to complications in health/disease management and in turn into a PPA. Projects 20 and 21 are also very important in ensuring that patients transition from inpatient settings to either immediate follow-up or appropriate post-acute services that can prevent re-admissions because they focus on continuity.

The associated Category 3 Outcome measures all contribute to managing patients for better outcomes and avoidance of complications that can lead to PPAs. Outcomes measures focusing on Diabetes tests, blood pressure monitoring and hypertension management are in many of the projects.

Our goal is to reduce PPAs by at least 5% each year.

RD-2. 30-day readmissions – This domain will also be important for each of the projects. Our hospital has higher than expected readmission rates and this also will be a major project of the re-engineering process improvement that will be part of each of these projects. Our goal is to decrease the number of readmissions by 5 percent in each of years 4 and 5. This Reporting Domain will be affected by all of the following projects, in much the same manner as RD 1.

1. 126686802.1.1 – Newly established primary care clinic
2. 126686802.1.2 – Expanding existing primary care network
3. 126686802.1.3 – Implementing a Quality Incentive Program for PCP Network
4. 126686802.1.4 – Introduce a Telemedicine/Telehealth system
5. 126686802.1.5 – Newly established specialty care clinic
6. 126686802.1.6 – Develop population management infrastructure
7. 126686802.1.7 – CME Program expansion for community PCPs
8. 126686802.1.8 – Family Medicine Residency training programs
9. 126686802.1.9 – PA program expansion

10. 126686802.1.10 – Training Community Workers
11. 126686802.1.11 – Urgent Care Service for Cancer Patients
12. 126686802.1.12 – Quality Improvement Center
13. 126686802.2.1 – Expanding Medical Home in PCP Network
14. 126686802.2.2 – Expand Quality Improvement Training
15. 126686802.2.4 – Implement Care Coordination with PCP network
16. 126686802.2.5 – Implement Care Transitions with PCP network
17. 126686802.2.6 – Conduct Medication Management
18. 175287501.1.1 – Transplant Program
19. 175287501.2.1 – Implement ED Navigator Program
20. 175287501.2.2 – Implement Palliative Care Program
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Each of these projects will contribute to reducing potentially preventable admissions. Projects 1-6 provide greater access to ambulatory care and additional tools for Primary Care Providers to help patients manage their health with going to the ED or into the hospital. Projects 7-8 involve education providers to use more health care and population management tools to help patients stay healthier. Project 11 and 19 are particularly important in helping cancer patients urgent care support at their ambulatory clinic rather than resorting to an ED visit when complications arise. In its first month of operation, this project document over 40 prevented admissions. Project 19 works with patients when they arrive at the ED to get quicker attention and/or referral to more appropriate settings. Projects 15 and 16 help patient get the next step of care that is too often missed, which can lead to complications in health/disease management and in turn into a PPA. Projects 20 and 21 are also very important in ensuring that patients transition from inpatient settings to either immediate follow-up or appropriate post-acute services that can prevent re-admissions because they focus on continuity.

The associated Category 3 Outcome measures all contribute to managing patients for better outcomes and avoidance of complications that can lead to PPAs. Outcomes measures focusing on Diabetes tests, blood pressure monitoring and hypertension management are in many of the projects. The associated Category 3 Outcome measures all contribute to managing patients for better outcomes and avoidance of complications that can lead to reductions in the 30-day re-admission rates.

Our goal is to reduce PPAs by at least 5% each year.

RD-3. Potentially Preventable Complications (PPCs) – Each of the Category 1, 2 and 3 hospital projects will benefit from decreasing preventable complications of hospitalization. The re-engineering process improvement of each of the projects should result in a decrease in complication for hospitalized patients.

This Reporting Domain will be affected by all of the following projects

1. 126686802.1.12 – Quality Improvement Center
2. 126686802.2.2 – Expand Quality Improvement Training
3. 126686802.2.4 – Implement Care Coordination with PCP network
4. 126686802.2.5 – Implement Care Transitions with PCP network
5. 175287501.1.1 – Transplant Program
6. 175287501.2.2 – Implement Palliative Care Program
7. 175287501.2.3 – Transitional Care Services for Cancer Inpatients

Projects that train physicians and clinical staff in quality/process improvement skills lead to changes in how inpatient care is provided, which can lead to avoiding hospital-acquired conditions that result for poor processes. Care coordination and care transitions that are managed from either the inpatient side or by primary care providers bringing patients back into the community result in closer patient monitoring and avoidance of potential complications. The Transplant program is specifically focused on preventing central line-associated infections.

Our goal is to reduce these complications by 5% per year for years 4 and 5.

RD-4. Patient-centered Healthcare – Both patient satisfaction and medication management/medication safety will be a component measured in all of the patients of hospital projects in this section.

Patient satisfaction surveys are conducted on a sampling of all inpatients and outpatients. Satisfaction results will be tracked for all projects. Survey results are reviewed regularly by the hospitals and clinics.

One project in particular is focused on medication management.
126686802.2.6 – Conduct Medication Management

Our goals in this area will be determined in the DY2 and DY3 with significant improvement expected.

RD-5. Emergency Department – Again all of the hospital projects will be affected by this domain in that all will involve patients with high emergency department utilization. The following projects will have the most direct influence on this reporting domain.

1. 126686802.1.11 – Urgent Care Service for Cancer Patients
2. 126686802.1.12 – Quality Improvement Center
3. 126686802.2.2 – Expand Quality Improvement Training
4. 175287501.2.1 – Implement ED Navigator Program

The first project will provide triage to cancer patients who experience problems and call the Cancer Center. The triage staff will determine if the patient needs to be seen in the clinic within 1 hour of the call, of if they should go to the ED. If the patient is sent to the ED, the Cancer Center staff collaborate with the ED staff to assure prompt and appropriate care so the patient can avoid a potentially preventable admission or a potential complication to their care or condition. Quality improvement training provides clinical staff with the skills to improve processes such as how patients move through the ED. The ED Navigator Program is specifically focused on the Domain due to the very nature of what it is designed to accomplish.

We will set goals for this domain in DY2 based on progress of the hospital projects.

RD-6. Optional Domain: Initial Core Set of Health Care Quality Measures – Since Medicaid funded patients will be included in all of the hospital projects, the core measure compliance rates will be affected by all of these projects. Our eventual goal will be 100% compliance with these core measures but the actual goals for DY4 and 5 will be determined during DY2.

The elements of The Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP that will be most affected by our projects will relate to prenatal care, obesity, and obstetrics-related measures. Due to our relationship with Children's Medical Center of Dallas, our pediatricians see most of the children at CMC's clinics. The projects that will influence these measures include:

1. 126686802.1.1 – Newly established primary care clinic
2. 126686802.1.2 – Expanding existing primary care network
3. 126686802.1.3 – Implementing a Quality Incentive Program for PCP Network
4. 126686802.1.4 – Introduce a Telemedicine/Telehealth system
5. 126686802.1.6 – Develop population management infrastructure

6. 126686802.1.7 – CME Program expansion for community PCPs
7. 126686802.1.8 – Family Medicine Residency training programs
8. 126686802.1.10 – Training Community Workers
9. 126686802.1.12 – Quality Improvement Center
10. 126686802.2.1 – Expanding Medical Home in PCP Network
11. 126686802.2.2 – Expand Quality Improvement Training
12. 126686802.2.4 – Implement Care Coordination with PCP network
13. 126686802.2.5 – Implement Care Transitions with PCP network
14. 126686802.2.6 – Conduct Medication Management
15. 175287501.1.1 – Transplant Program
16. 175287501.2.1 – Implement ED Navigator Program
17. 175287501.2.2 – Implement Palliative Care Program
18. 175287501.2.3 – Transitional Care Services for Cancer Inpatients

Projects 1, 2, 3, 4, 8, 9, 10, 12, 13, 14, and 16 will have the most direct impact. Primary care providers, especially obstetricians, address the measures around prenatal care and deliveries most often. Training providers in various ways to more closely monitor and take action with many of the measures will be a key tool in effecting change and improvement.

The Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults is addressed in many of the Category 3 Outcome measures associated with many of the projects. More specifically, measures #3, 4, 7, 16, 17, 19, 24 are addressed most often in outcome measures. Many of the other measures are part of the care provided in projects that increase access to primary and specialty care.

The Core set is:

NQF #	Measure Name
1	Flu Shots for Adults Ages 50-64 (Collected as part of HEDIS CAHPS Supplemental Survey)
2	Adult BMI Assessment
3	Breast Cancer Screening
4	Cervical Cancer Screening
5	Medical Assistance with Smoking and Tobacco Use Cessation (Collected as part of HEDIS CAHPS Supplemental Survey)

6	Screening for Clinical Depression and Follow-Up Plan
7	Plan All-Cause Readmission
8	PQI 01: Diabetes, Short-term Complications Admission Rate
9	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
10	PQI 08: Congestive Heart Failure Admission Rate
11	PQI 15: Adult Asthma Admission Rate
12	Chlamydia Screening in Women Ages 21-24
13	Follow-Up After Hospitalization for Mental Illness
14	PC-01: Elective Delivery
15	PC-03: Antenatal Steroids
16	Controlling High Blood Pressure
17	Comprehensive Diabetes Care: LDL-C Screening
18	Annual HIV/AIDS Medical Visit
19	Comprehensive Diabetes Care: Hemoglobin A1c Testing
20	Antidepressant Medication Management
21	Adherence to Antipsychotics for Individuals with Schizophrenia
22	Annual Monitoring for Patients on Persistent Medications
23	CAHPS® Health Plan Survey v 4.0—Adult Questionnaire with CAHPS® Health Plan Survey v 4.0H—NCQA Supplemental
24	Care Transition–Transition Record Transmitted to Health Care Professional
25	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
26	Prenatal and Postpartum Care: Postpartum Care Rate

Our related Category 3 Outcome Measures and their associated projects are:

Unique Category 3 Identifier	Outcome Refernce #	Outcome Measure (Improvement Target) Name from RHP Planning Protocol
126686802.3.1	IT-12.1	Breast Cancer Screening
126686802.3.2	IT-12.3	Colorectal Cancer Screening
126686802.3.3	IT-12.4	Pneumonia vaccination status of older adults
126686802.3.4	IT-12.1	Breast Cancer Screening
126686802.3.5	IT-12.3	Colorectal Cancer Screening
126686802.3.6	IT-12.4	Pneumonia vaccination status of older adults
126686802.3.7	IT-12.1	Breast Cancer Screening
126686802.3.8	IT-12.3	Colorectal Cancer Screening
126686802.3.9	IT-12.4	Pneumonia vaccination status of older adults
126686802.3.10	IT-1.6	Cholesterol Management for patients with cardiovascular conditions
126686802.3.11	IT-1.7	Controlling High Blood Pressure
126686802.3.12	IT-1.10	Diabetes care: HbA1c poor control (>9.0%)

126686802.3.13	IT-1.6	Cholesterol Management for patients with cardiovascular conditions
126686802.3.14	IT-1.7	Controlling High Blood Pressure
126686802.3.15	IT-12.1	Breast Cancer Screening
126686802.3.16	IT-12.3	Colorectal Cancer Screening
126686802.3.17	IT-12.4	Pneumonia vaccination status of older adults
126686802.3.18	IT-1.7	Controlling High Blood Pressure
126686802.3.19	IT-12.1	Breast Cancer Screening
126686802.3.20	IT-12.3	Colorectal Cancer Screening
126686802.3.21	IT-12.4	Pneumonia vaccination status of older adults
126686802.3.22	IT-1.10	Diabetes care: HbA1c poor control (>9.0%)
126686802.3.23	IT-3.1	All cause 30 day readmission rate
126686802.3.24	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery
126686802.3.25	IT-1.10	Diabetes care: HbA1c poor control (>9.0%)
126686802.3.26	IT-3.1	All cause 30 day readmission rate
126686802.3.27	IT-1.10	Diabetes care: HbA1c poor control (>9.0%)
126686802.3.28	IT-3.1	All cause 30 day readmission rate
126686802.3.29	IT-1.20	Other Outcome Improvement Target: Number of primary care practitioners in HPSAs or MUAs who report they plan to implement chronic disease management
126686802.3.30	IT-14.1	Number of practicing primary care practitioners per 1000 individuals in HPSAs or MUAs
126686802.3.31	IT-14.4	Number of graduates who practice in a HPSA or MUA
126686802.3.32	IT-1.7	Controlling high blood pressure
126686802.3.33	IT-9.2	ED appropriate utilization - Reduce ED visits for target conditions
126686802.3.34	IT-2.13	Other Admission Rate - admissions due to complications of cancer treatment
126686802.3.35	IT-3.1	All cause 30 day readmission rate
126686802.3.36	IT-3.12	Other - readmission rate (Medication complications)

175287501.3.1	IT-1.20	Other Outcomes Improvement Target. Outcomes of Bone Marrow and Solid Organ Transplant
175287501.3.2	IT.2.12	Prevention Quality Indicators (PQI) Composite Measure Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions

175287501.3.3	IT-13.1	Pain Assessment
175287501.3.4	IT-13.2	Treatment Preferences
175287501.3.5	IT-13.5	Percentage of patients receiving hospital 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 disucss.
175287501.3.6	IT-3.2	Other - Readmission Rate. Cancer Patient Readmissions.

Domain Valuation: The valuation for each domain considered various factors including size of the domain, project scope, populations served, community benefit, cost avoidance, addressing priority community need, and estimated local funding.

Category 4: Population-Focused Measures *University of Texas Southwestern University Hospitals/TPI 175287501*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$468,721	$500,000	$0	$0
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount	$0	$225,986	$290,608	$315,878
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount	$0	$225,986	$290,608	$315,878
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	$0	$0	$290,607	$315,878
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		12-month	12-month	12-month
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		12-month	12-month	12-month
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount	$0	$225,986	$290,607	$315,877
Domain 5: Emergency Department				
Measurement period for report		12-month	12-month	12-month
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive	$0	$225,986	$290,607	$315,877

Amount				
OPTIONAL Domain 6: Children and Adult Core Measures				
Frequency of ongoing prenatal care				
Measurement period for report		12-month	12-month	12-month
Planned Reporting Period: 1 or 2		2	2	2
Timeliness of prenatal care				
Measurement period for report		12-month	12-month	12-month
Planned Reporting Period: 1 or 2		2	2	2
Cesarean rate for low-risk first birth women				
Measurement period for report		12-month	12-month	12-month
Planned Reporting Period: 1 or 2		2	2	2
Percent of live births weighing <2500 grams				
Measurement period for report		12-month	12-month	12-month
Planned Reporting Period: 1 or 2		2	2	2
Pediatric central-line associated bloodstream infection (CLASBI) rates				
Measurement period for report		12-month	12-month	12-month
Planned Reporting Period: 1 or 2		2	2	2
Elective delivery prior to 39 weeks completed gestation				
Measurement period for report		12-month	12-month	12-month
Planned Reporting Period: 1 or 2		2	2	2
Appropriate use of antenatal steroids				
Measurement period for report		12-month	12-month	12-month
Planned Reporting Period: 1 or 2		2	2	2
Postpartum Care Rate				
Measurement period for report		12-month	12-month	12-month
Planned Reporting Period: 1 or 2		2	2	2
Domain 6 - Estimated Maximum Incentive Amount	$0	$225,986	$290,607	$315,877
Grand Total Payments Across Category 4	$468,721	$1,629,929	$1,743,644	$1,895,265

Section VI. RHP Participation Certifications

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- 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.

Certifications Follow in This Order

Entity / System	Entity Type	Plan Participation
Baylor Health Care System	Hospitals	4 DSRIP Performing Providers 2 UC-Only Hospitals
Children's Medical Center Dallas	Hospital – Children's	1 DSRIP Performing Provider
HCA North Texas	Hospitals	4 DSRIP Performing Providers 1 UC-Only Hospital
Methodist Health Care System	Hospitals	3 DSRIP Performing Providers
Parkland Memorial Hospital	Hospital	1 DSRIP Performing Provider
Tenet North Texas	Hospital	1 DSRIP Performing Provider
Texas Health Resources	Hospitals	3 DSRIP Performing Providers
Terrell State Hospital	Hospital	1 UC-Only Hospital
UT Southwestern Medical Center	Academic Physician Practice Plan Hospital	2 DSRIP Performing Providers
Dallas County Health and Human Services	Local Health Department	1 DSRIP Performing Provider
Denton County Health and Human Services	Local Health Department	1 DSRIP Performing Provider
Dallas County MHMR / Metrocare Services	County MHMR	1 DSRIP Performing Provider
Denton County MHMR	County MHMR	1 DSRIP Performing Provider
Lakes Regional MHMR Center	County MHMR	1 DSRIP Performing Provider
Ector County Hospital District	IGT Source	IGT Entity
Texas A&M Health Science Center – Baylor College of Dentistry	Other	1 DSRIP Performing Provider

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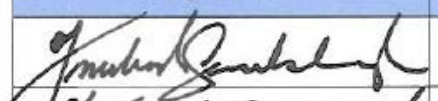
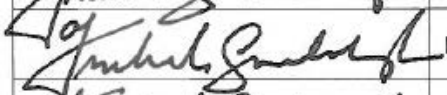
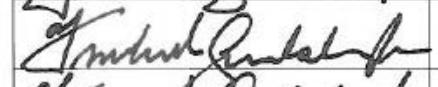
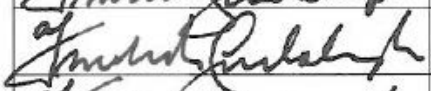
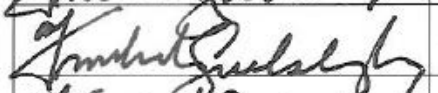
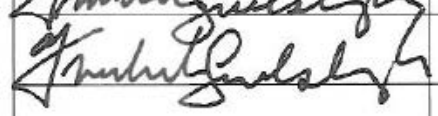
	Fred Savelsbergh	Baylor Heart and Vascular Hospital
	Fred Savelsbergh	Trinity Medical Center d/b/a Baylor Medical Center at Carrollton
	Fred Savelsbergh	Baylor Medical Center at Garland
	Fred Savelsbergh	Baylor Medical Center at Irving
	Fred Savelsbergh	Baylor Specialty Hospital
	Fred Savelsbergh	Baylor University Medical Center

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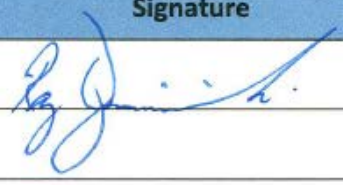	Ray Dziesinski	Children's Medical Center Dallas

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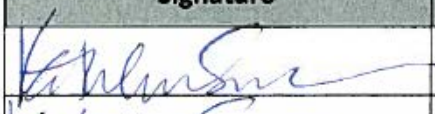
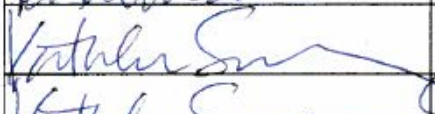
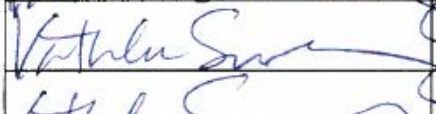
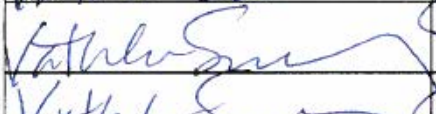
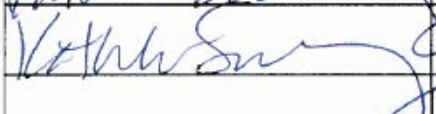
	Kathleen Sweeney	Denton Regional Medical Center
	Kathleen Sweeney	Green Oaks Hospital
	Kathleen Sweeney	Las Colinas Medical Center
	Kathleen Sweeney	Medical Center of Lewisville
	Kathleen Sweeney	Medical City Dallas Hospital

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Signature	Name	Organization
Michael Schaefer	Michael Schaefer	Methodist Charlton Medical Center
Michael Schaefer	Michael Schaefer	Methodist Dallas Medical Center
Michael Schaefer	Michael Schaefer	Methodist Richardson Medical Center

Section VI. RHP Participation Certifications

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Signature	Name	Organization
	Ted Shaw	Parkland Memorial Hospital

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Signature	Name	Organization
	Wes James	Doctor's Hospital at White Rock Lake

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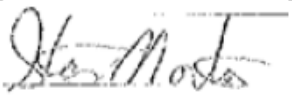
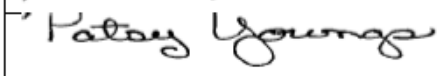
Signature	Name	Organization
	Britt Berrett	Texas Health Presbyterian Hospital Dallas
	Stan Morton	Texas Health Presbyterian Hospital Denton
	Patsy Youngs	Texas Health Presbyterian Hospital Kaufman

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Signature	Name	Organization
W.R. Wheeler	Bill Wheeler, CFO, DSHS	Terrell State Hospital

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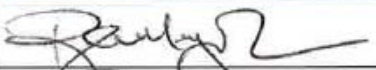
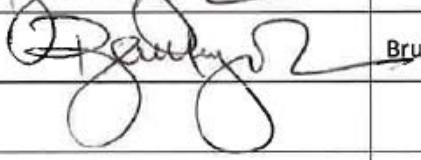
	Bruce A. Meyer, MD, MBA	UT Southwestern Medical Center – Faculty Practice Plan
	Bruce A. Meyer, MD, MBA	UT Southwestern Medical Center – St. Paul University Hospital

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Signature	Name	Organization
	Zachary Thompson	Dallas County Health and Human Services

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	Bing Burton	Denton County Health Department

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Signature	Name	Organization
Linda Thompson	Linda Thompson, Interim CEO	Dallas County MHMR Center d/b/a Metrocare Services

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Signature	Name	Organization
Pam Gutierrez	Pam Gutierrez	Denton County MHMR

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Signature	Name	Organization
	John Delaney, Exec. Director	Lakes Regional MHMR Center

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Signature	Name	Organization
	William Webster	Ector County Hospital District

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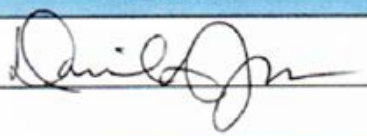	Daniel L. Jones, DDS, PhD	Texas A&M Health Science Center – Baylor College of Dentistry

Section VII. Addendums

- *Private hospital certifications – refer to Companion Document for additional details.*
- *List of DSRIP projects that were considered but not selected for inclusion in the RHP Plan*
- *Signed agreements of small hospitals participating in a collaboration in Pass 1 as allowed in the PFM Protocol, paragraph 25.c.iii.*
- *Signed agreements of Tier 3 and 4 Performing Providers that combined their Pass 1 allocations as allowed in the PFM Protocol, paragraph 25.c.iv.*
- *Signed agreements of Performing Providers that combined their Pass 2 allocations as allowed in the PFM Protocol, paragraph 25.d.iii.*
- *Optional: additional community assessment information*
- *Optional: supporting evidence of stakeholder participation (e.g. meeting lists, minutes, letters of support)*
- *Optional: additional valuation information*